

10459

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>5 Days</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>14 College Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4. DATE OF DEATH Month <u>Sept</u> Day <u>12</u> Year <u>19 58</u>	
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>M.</u> Last <u>Ahalt</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-8-07</u>		9. AGE (In years lost birthday) <u>51</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER K3M</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Penn</u>	
13. FATHER'S NAME <u>ALONZA AHAIT</u>		14. MOTHER'S MAIDEN NAME <u>HATTIE-7100K</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MARY JANE AHAIT</u> Address <u>COLLEGE PARK</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis and Hemorrhage of Pons</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Aneurysm of the Basilar Artery</u> DUE TO (c) <u>Cerebral Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>?</u> <u>2 years</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>7-11</u> , 19 <u>58</u> , to <u>9-12</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9-12</u> , 19 <u>58</u> , and that death occurred at <u>8:30 P.M.</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>2513 Buck Lodge Rd. Bethesda Md.</u> DATE SIGNED <u>9/12/58</u> ACTUAL SIGNATURE <u>R.D. BAKER M.D.</u> PHYSICIAN'S (Type) <u>R.D. BAKER, M.D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9-16-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LUTHERAN</u>	
22d. LOCATION (City, town, or county) (State) <u>FREEDRICKTOWN, MD</u>		24a. REC'D BY REGISTRAR <u>SEP 16 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>GLADHILL COMPANY MIDDLEBURY MD</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10460

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital			d. STREET ADDRESS 5407 38th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Gordon Middle Randolph Last Arrington			4. DATE OF DEATH Month September Day 3 Year 19 58		
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-21-1911		9. AGE (In years last birthday) 47 yrs. IF UNDER 1 YEAR: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Central office repairman Telephone		10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME Edward Dickerson Arrington			14. MOTHER'S MAIDEN NAME Clara Thompson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 216-05-6539		17. INFORMANT Address Cecelia Rose Arrington; same address as #2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 6, 1958		22c. NAME OF CEMETERY OR CREMATORY Springfield Cemetery	
22d. LOCATION (City, town, or county) (State) Sykesville, Maryland.		23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Maryland.			
24a. REC'D BY REGISTRAR DATE SEP 5 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Hines			

STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased John T. Salway, M.D.		Age 50		Sex Male		Race White	
Date of Death October 3, 1950		Place of Death New York City		Cause of Death Acute congestive heart failure		Manner of Death Natural	
Residence 2107 10th Avenue		Occupation Physician		Education M.D.		Religion Catholic	
Marital Status Married		Date of Marriage 1925		Place of Birth New York City		Date of Birth October 3, 1900	
Signature of Medical Examiner John T. Salway, M.D.		Signature of Coroner John T. Salway, M.D.		Signature of Registrar John T. Salway, M.D.		Signature of Burial Officer John T. Salway, M.D.	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10436

Reg. Dist. No.

10461

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 5810 43rd Avenue			
3. NAME OF DECEASED (Type or print) Charles William Baker				4. DATE OF DEATH Sept. 5 1958			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 8, 1902		9. AGE (in years last birthday) 56 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY School rooms		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry H. Baker				14. MOTHER'S MAIDEN NAME Mary Hall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-09-7215		17. INFORMANT Address Jean Ray Baker; same address as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Sept. 7th, 1958			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/8/58		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS 1739 Balto. Av. Hyattsville, Md.		24. REGISTRY BY REGISTRAR DATE SEP 9 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE STATE
DEATH CERTIFICATE

DATE OF DEATH
1950

PLACE OF DEATH

NAME OF DECEASED

DATE OF BIRTH

SEX

RACE

EDUCATION

PLACE OF BIRTH

DATE OF BIRTH

NAME OF DECEASED

DATE OF BIRTH

SEX

RACE

EDUCATION

DATE OF DEATH

PLACE OF DEATH

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CERTIFICATE OF DEATH

Reg. Dist. No. 10437

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Charles ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews AFB				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head, Md. 08x-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS				d. STREET ADDRESS 32 Diffenbach Court			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Shirley Geraldine Banks				4. DATE OF DEATH Month Day Year Sept 26 1958			
5. SEX F	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 25 Mar 35		9. AGE (In years lost birthday) 23 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during kind of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Ernest Roache				14. MOTHER'S MAIDEN NAME Mollie Todd			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unk		17. INFORMANT Address Mollie Roache(M) 1507 Lincoln Pl Hopewell, Va.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 241X DUE TO Acute Bronchial Asthma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Recurrent Bronchial Asthma since age 6 DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 3 wks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 25 Sep, 1958, to 26 Sep, 1958, that I last saw the deceased alive on 26 Sep, 1958, and that death occurred at 2215 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED USAF Hospital, Andrews AFB, Md. 26 Sep 58							
ACTUAL SIGNATURE Sidney B. Kern M.D.				PHYSICIAN'S NAME (Type) SIDNEY B. KERN, MAJ USAF(MC) USAF Hospital, Andrews AFB, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 30/58		22c. NAME OF CEMETERY OR CREMATORY National Cemetery		22d. LOCATION (City, town, or county) (State) Hopewell Va	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur L. Kraus				24a. REC'D BY REGISTRAR DATE SEP 30 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1918

101

1. NAME OF DECEASED		2. SEX		3. AGE		4. PLACE OF BIRTH	
JAMES J. O'NEILL		Male		45		New York City, N.Y.	
5. DATE OF DEATH		6. TIME OF DEATH		7. PLACE OF DEATH		8. CAUSE OF DEATH	
October 10, 1918		10:30 A.M.		Home		Pneumonia	
9. OCCUPATION		10. MARITAL STATUS		11. EDUCATION		12. RELIGION	
Clerk		Married		High School		Roman Catholic	
13. PRESENT ADDRESS		14. DATE OF BIRTH		15. DATE OF MARRIAGE		16. DATE OF DEPARTURE	
101 West 10th St., Boston		October 10, 1873		October 15, 1895		October 10, 1918	
17. SIGNATURE OF DECEASED		18. SIGNATURE OF WITNESSES		19. SIGNATURE OF PHYSICIAN		20. SIGNATURE OF REGISTRAR	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 1918

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10438
Reg. Dist. No.

10462

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Prince Geo, b. COUNTY Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) Benjamin First Barkley Middle Last			4. DATE OF DEATH Month September Day 5, Year 19 58		
5. SEX Male	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 19, 1927		9. AGE (In years last birthday) 31 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Foundry		11. BIRTHPLACE (State or foreign country) Alabama	
13. FATHER'S NAME Judge Barkley			14. MOTHER'S MAIDEN NAME Lucy Gunn		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mattie Barkley Address Gadsden, Ala.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive heart failure 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchopneumonia DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John T. Maloney		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Sept. 5, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept-10-58	22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines & Co. 3015 12th St., NE		24a. REC'D BY REGISTRAR SEP 16 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John T. Palmer, Jr.	
Sex		Male	
Race		Caucasian	
Age		38	
Date of Birth		September 15, 1928	
Place of Birth		Baltimore, Maryland	
Usual Residence		Baltimore, Maryland	
Cause of Death		Congestive heart failure	
Manner of Death		Natural	
Signature of Medical Examiner		John T. Palmer, Jr.	
Date		September 2, 1968	

10463

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale Hills, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 25 Riverdale Hills, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) 6208 Sheridan Street,.		d. STREET ADDRESS 6208 Sheridan St	
3. NAME OF DECEASED (Type or print) First Middle Last Russell WILLIAM Bean		4. DATE OF DEATH Month Day Year Sept 4, 19 58	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 16, 1897
9. AGE (In years last birthday) yrs. 61		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operating Engineer U		10b. KIND OF BUSINESS OR INDUSTRY S Botanic Gardens Illinois	
11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John U. Bean		14. MOTHER'S MAIDEN NAME Cora Sechler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) none	
17. INFORMANT Bessie G. Bean		Address Riverdale Hills, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Lung DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			INTERVAL BETWEEN ONSET AND DEATH 3 Mo 6 Mo
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I attended the deceased from July 28, 1958, to Sept. 4, 1958, that I last saw the deceased alive on Sept. 1, 1958, and that death occurred at 9:30 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Harold Heiges M.D. 1835 Eye St NW PHYSICIAN'S NAME (Type) Harold Heiges Washington DC			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept 8, 1958	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Colmar Manor, Maryland.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland.	24a. REC'D BY REGISTRAR DATE SEP 9 '58
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10447

CERTIFICATE OF DEATH

Reg. Dist. No.

10441

1. PLACE OF DEATH o. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY P. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 COLLEGE PARK	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5801 42nd AVE, Hy. Conv. Home		d. STREET ADDRESS 1 8703 49th AVE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EDWARD Middle BURGER Last BECKWITH		4. DATE OF DEATH Month SEPT Day 10 Year 1958	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 21, 1874
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) U. S. A. state (unknown)		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME THOMAS A. BECKWITH		14. MOTHER'S MAIDEN NAME MAGGIE RHINE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Caroline Burriss		Address 3605 Metzger Rd. College Park Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 239X DUE TO INANITION + TOXEMIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Epidermoid Carcinoma E Metastatic DUE TO (c) 2 YRS.		INTERVAL BETWEEN ONSET AND DEATH WEEKS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from SEPT. 9, 1957 , to Sept. 9, 1958 , that I last saw the deceased alive on Sept 9, 1958 , and that death occurred at 10:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Arnold Lear		M.D. 905 SHERIDAN ST. 9-10-58	
PHYSICIAN'S NAME (Type) Arnold Lear		HYATTSVILLE, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/12/58	
22c. NAME OF CEMETERY OR CREMATORY Rock Creek		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis Gaschs Sons Hyattsville, Md.		24. REGISTRAR'S SIGNATURE Arthur S. Huns	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10442

FOR STATE HEALTH DEPT.

Reg. Dist. No.

10517

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berwyn Heights		c. LENGTH OF STAY IN 1b 43 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8403 58th Avenue		e. STREET ADDRESS 8403 58th Avenue	
3. NAME OF DECEASED (Type or print) Margaret Rushford Benson		4. DATE OF DEATH Month September Day 10 Year 19 58	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-16- 1868
9. AGE (In years last birthday) 90 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Marshall Quinn		14. MOTHER'S MAIDEN NAME Isabelle Livingston	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO.	
17. INFORMANT Doris E. Ring;		Address 1709 Woodman Avenue Silver Springs, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c)</p> </div> <div style="width: 15%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Large abscess of left kidney			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/13/58	
22c. NAME OF CEMETERY OR CREMATORY Rock Creek		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons		ADDRESS 1739 Balto. Av Hyattsville, Md.	
DATE SEP 15 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Howard	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>NAME OF DECEASED John F. Mowery</p>		<p>RESIDENCE 1009 Westmore Avenue Baltimore, Md.</p>	
<p>DATE OF DEATH Sept. 10, 1933</p>		<p>PLACE OF DEATH Home</p>	
<p>AGE 60 years</p>		<p>SEX Male</p>	
<p>RACE White</p>		<p>RELIGION Roman Catholic</p>	
<p>EDUCATION High School</p>		<p>OCCUPATION None</p>	
<p>PREVIOUS ILLNESS Cardiovascular disease</p>		<p>CAUSE OF DEATH Coronary thrombosis</p>	
<p>DETAILS OF ILLNESS Large aneurysm of left kidney</p>		<p>DATE OF EXAMINATION Sept. 10, 1933</p>	
<p>SIGNATURE OF EXAMINER John F. Mowery</p>		<p>DATE Sept. 10, 1933</p>	
<p>PLACE Baltimore, Md.</p>		<p>STATE Maryland</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10518

10443

1. PLACE OF DEATH o. COUNTY <u>Primer Heights</u> <u>5006 - Nye St. N.E. MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>P. Geo's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maryland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>5006 - Nye St. N.E.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CLARA</u> Middle <u>ELIZABETH</u> Last <u>BISCOE</u>		4. DATE OF DEATH Month <u>9</u> Day <u>27</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 11 1873</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES BEAL</u>		14. MOTHER'S MAIDEN NAME <u>CATHRIWE DYSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>5127 - 2701</u>	
17. INFORMANT <u>Allice Biscoe</u>		Address <u>5006 - Nye St. N.E.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left Ventricular Failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Coronary Heart Disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 mos</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>56</u> , to <u>25 Sept.</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>25 Sept.</u> , 19 <u>58</u> , and that death occurred at <u>3:15</u> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Carly H. Johnson</u>		DATE SIGNED <u>9/27/58</u>	
PHYSICIAN'S NAME (Type) _____		ADDRESS (Street, city or town, state) _____	
22a. BURIAL, CREMATION, REMOVAL (Specify) _____		22b. DATE THEREOF <u>10-1-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Memorial Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Southwest Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WERNERST</u>		ADDRESS <u>1432 Youst St. N.E.</u>	
24a. REC'D BY REGISTRAR <u>OCT 1 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

10519

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1, 22 Film G23L 9/21/58

CERTIFICATE OF DEATH

10444

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY PRINCE GEORGE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Hgths		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HILLCREST Hgths.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5906 24th Ave.		d. STREET ADDRESS 5906. 24th AVE	
3. NAME OF DECEASED (Type or print) THOMAS. A. BLIGH, SR.		4. DATE OF DEATH SEPT. 17 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 30 1898
9. AGE (In years, last birthday) 60 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RAILWAY EXPRESS AGENCY		10b. KIND OF BUSINESS OR INDUSTRY WASH. D.C.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME THOMAS A. BLIGH		14. MOTHER'S MAIDEN NAME MARGARET E. MULHIGAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 714-07-9001	
17. INFORMANT THOMAS A. BLIGH, JR.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Gastrointestinal hemorrhage DUE TO Pulmonary infarct, LLL DUE TO Red Duodenal ulcer Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 2 hours 4 months 1 1/2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-15-1958 to 9-17-1958 that I last saw the deceased alive on 9-17-1958 and that death occurred at 2:45 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE David S. Gordon M.D.		ADDRESS (Street, city or town, state) 5731 23rd Parkway SE Wash. 21, D.C.	
DATE SIGNED 9-17-58			
PHYSICIAN'S NAME (Type) DAVID S. GORDON, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9.20.1958	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland Md	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home		ADDRESS 300. 4th st N.E.	
24a. REC'D BY REGISTRAR SEP 19 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kneib	

DAVID ? GARRON, MD
2000, 21, 0.5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10445

10520

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47 X-3	
c. LENGTH OF STAY IN 1b 2 yrs., 11 mos., & 22 days.		d. STREET ADDRESS 1121 12th St., N. W.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Frank B. Blundell		4. DATE OF DEATH Month 9 Day 19 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH 8/29/04	9. AGE (In years lost birthday) 54 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal Worker		10b. KIND OF BUSINESS OR INDUSTRY Air duct insulation	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Blundell		14. MOTHER'S MAIDEN NAME Laura German	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 374-09-9653	
17. INFORMANT Decedent		Address -	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized peritonitis 540.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Perforated duodenal ulcer DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/28, 19 55, to 9/19, 19 58, that I last saw the deceased alive on 9/19, 19 58, and that death occurred at 1:25 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Moe Weiss		ADDRESS (Street, city or town, state) Glenn Dale Hospital	
DATE SIGNED 9/19/58			
PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		Glenn Dale, Md.	
22a. BURIAL CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 9-23-58	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION City, town, or county (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins		ADDRESS 3821-14 St NW Washington, D.C.	
24a. REC'D BY REGISTRAR DATE SEP 29 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

10448

CERTIFICATE OF DEATH

10446

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE		c. LENGTH OF STAY IN 1b 2 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2007 ERIE STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELSIE Middle M. Last BOLD		4. DATE OF DEATH Month SEPT. Day 22 Year 19 58	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 6, 1889
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown Olsen		14. MOTHER'S MAIDEN NAME Hanna unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT George A. Bold, 2007 Erie St., Hyattsville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 170X DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) Generalized Carcinomatosis DUE TO (c) Adenocarcinoma Left breast		INTERVAL BETWEEN ONSET AND DEATH 12 hrs 12 mos 12 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. — 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/6 , 19 58 , to 9/22 , 19 58 , that I last saw the deceased alive on 9/21 , 19 58 , and that death occurred at 9:35 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Frank M. Trozzo Jr. M.D.		ADDRESS (Street, city or town, state) 1840 Michigan Ave N.E. DATE SIGNED 9/22/58	
PHYSICIAN'S NAME (Type) FRANK M TROZZO JR		1840 MICH AVE NE D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
TRANS. & BURIAL	9/24/58	PINE VIEW CEMETERY	GLENN FALLS, NEW YORK
23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Guika		24a. REC'D BY REGISTRAR SEP 23 '58	
ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10521 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 10447

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Heights		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Heights	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2802 - Keating St		d. STREET ADDRESS 12802 - Keating Street	
3. NAME OF DECEASED (Type or print) Mildred Ann Bond		4. DATE OF DEATH Month Sept Day 22 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6 1915
9. AGE (in years last birthday) 43 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME Charles Briggs		14. MOTHER'S MAIDEN NAME Unk.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 262-17-1069	
17. INFORMANT Unk. Leslie E. Bond.		Address Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X Japoxemia DUE TO (b) Klebsiella broncho pneumonia (c) bilateral CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Bond M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Bond		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Sept 22, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-26-1958	
22c. NAME OF CEMETERY OR CREMATORY WASHINGTON CEM		22d. LOCATION (City, town, or county) (State) SUITLAND MD	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co		24a. REC'D BY REGISTRAR SEP 25 '58	
ADDRESS 517-11th St S.E.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in. The funeral director should be notified immediately. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
10522 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 2 Film G234 9/25/58 ggj
CERTIFICATE OF DEATH

10449

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>North Carolina</u> b. COUNTY <u>Wallace</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shutland Rd</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wallace</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4856 Sunset Lane SE, DC 23</u>		d. STREET ADDRESS <u>70x-3</u>	
3. NAME OF DECEASED (Type or print) <u>IRLEN B</u> First Middle Last		4. DATE OF DEATH Month <u>Sept</u> Day <u>18</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 23, 1893</u> AGE (In years last birthday) <u>65</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NO CAROLINA</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JAMES HENRY</u>		14. MOTHER'S MAIDEN NAME <u>IRLEN SAVAGE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>RUBY B VALENTE</u> Address <u>4856 LANE</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> DUE TO <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General Arteriosclerosis</u> DUE TO (c) <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Natural Cause</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 17, 1958</u> , to <u>Sept 18, 1958</u> , that I last saw the deceased alive on <u>Sept 18, 1958</u> , and that death occurred at <u>1235</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul C Van Natta</u> M.D. <u>5440 Silver Hill Rd SE</u>		ADDRESS (Street, city or town, state) <u>Washington DC</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>PAUL C VAN NATTA M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept 20/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brice Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Rt 2-Wallace, North Carolina</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home Wash. DC</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>SEP 22 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

100325

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	
JAMES H. HARRIS		M		45		W		10/15/1905		BALTIMORE, MD		10/20/1950		BALTIMORE, MD		HEART DISEASE		NATURAL		J. H. HARRIS		J. H. HARRIS	
13. OCCUPATION		14. EDUCATION		15. RELIGION		16. MARITAL STATUS		17. PREVIOUS ILLNESS		18. PREVIOUS SURGERY		19. PREVIOUS TRAUMA		20. PREVIOUS DRUGS		21. PREVIOUS ALCOHOL		22. PREVIOUS TOBACCO		23. PREVIOUS OTHER		24. PREVIOUS OTHER	
CLERK		HIGH SCHOOL		METHODIST		MARRIED		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS		31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS		34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

Dr. James H. Harris

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10464

CERTIFICATE OF DEATH

10450

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chervely		c. LENGTH OF STAY IN 1b 32 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Bowie			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 125 10th St. East		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Beulah Middle Brickerd Last Brickerd				4. DATE OF DEATH Month Sept. Day 10 Year 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7 Oct. 1908		9. AGE (In years last birthday) yrs. 49	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Largo, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Norman Beckett				14. MOTHER'S MAIDEN NAME Eva Moreland			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Theodore I Brickerd Bowie, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 175.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma Left Ovary DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4 yrs 5 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 1953 to Sept. 10, 1958 , that I last saw the deceased alive on Sept. 9, 1958 , and that death occurred at 5:15 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Wm. A. Holbrook PHYSICIAN'S NAME (Type) Wm. A. Holbrook				ADDRESS (Street, city or town, state) 4500 College Ave. College Park, Md. DATE SIGNED 9/10/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 12, 1958		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE SEP 15 '58	
						24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

FILE NO. 10

DECEASED'S NAME (Print Name and Surname)
 LAST NAME FIRST NAME MIDDLE NAME

AGE

SEX

DATE OF BIRTH (Month, Day, Year)

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH (Print Name of Disease or Injury)

PLACE OF DEATH (Print Name of Hospital, Home, or Other Place)

DATE OF INTERMENT (Month, Day, Year)

PLACE OF INTERMENT (Print Name of Cemetery or Other Place)

DATE OF BURIAL (Month, Day, Year)

PLACE OF BURIAL (Print Name of Cemetery or Other Place)

DATE OF CREMATION (Month, Day, Year)

PLACE OF CREMATION (Print Name of Crematorium or Other Place)

DATE OF EXHUMATION (Month, Day, Year)

PLACE OF EXHUMATION (Print Name of Cemetery or Other Place)

DATE OF REINTERMENT (Month, Day, Year)

PLACE OF REINTERMENT (Print Name of Cemetery or Other Place)

DATE OF RECREMATION (Month, Day, Year)

PLACE OF RECREMATION (Print Name of Crematorium or Other Place)

DATE OF REEXHUMATION (Month, Day, Year)

PLACE OF REEXHUMATION (Print Name of Cemetery or Other Place)

DATE OF REINTERMENT (Month, Day, Year)

PLACE OF REINTERMENT (Print Name of Cemetery or Other Place)

DATE OF RECREMATION (Month, Day, Year)

PLACE OF RECREMATION (Print Name of Crematorium or Other Place)

DATE OF REEXHUMATION (Month, Day, Year)

PLACE OF REEXHUMATION (Print Name of Cemetery or Other Place)

DATE OF REINTERMENT (Month, Day, Year)

PLACE OF REINTERMENT (Print Name of Cemetery or Other Place)

DATE OF RECREMATION (Month, Day, Year)

PLACE OF RECREMATION (Print Name of Crematorium or Other Place)

DATE OF REEXHUMATION (Month, Day, Year)

PLACE OF REEXHUMATION (Print Name of Cemetery or Other Place)

DATE OF REINTERMENT (Month, Day, Year)

PLACE OF REINTERMENT (Print Name of Cemetery or Other Place)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10523

CERTIFICATE OF DEATH

10451

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Andrews A.F. Base</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>USAF Hospital Andrews</u>				d. STREET ADDRESS <u>1312 24th Street South</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HARRIET MAY BROWN</u>				4. DATE OF DEATH Month Day Year <u>September 25 1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cau</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>23 Sep 1878</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Pittsburgh, Penna</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Thomas Corde</u>				14. MOTHER'S MAIDEN NAME <u>EMMA Robinson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Mrs W. J. Kennard (Daugh)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>199.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic Carcinoma</u> DUE TO (c) <u>Carcinoma of Undetermined Site</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>unknown</u> <u>unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis Generalized</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>15 Sep 1958</u> , to <u>25 Sep 1958</u> , that I last saw the deceased alive on <u>25 Sep 1958</u> , and that death occurred at <u>1:00 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>26 Sep 1958</u> DATE SIGNED ACTUAL SIGNATURE <u>Bernard F. Clodius</u> M.D. <u>USAF Hospital Andrews A.F. Base, Wash DC</u>							
PHYSICIAN'S NAME (Type) <u>BERNARD F. CLODIUS, Capt USAF (MC)</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/27/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>UNION DALE, CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>Northside Pittsburg, Penn.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. CHAMBERS CO.</u>				ADDRESS <u>3072 M St, N.W.</u>		24a. REC'D BY REGISTRAR <u>SEP 29 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kraus</u>							

MAYLAND STATE DEPARTMENT OF HEALTH—DAIRY, 10

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10452

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

10465

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 College Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ioland Memorial Hospital			d. STREET ADDRESS 8805 49th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Frank Raymond Burton			4. DATE OF DEATH Month Day Year September 12 19 58		
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 10, 1882		9. AGE (In years last birthday) 75 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Machinist		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Frank Burton			14. MOTHER'S MAIDEN NAME Mary Lee		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Wallace L. Burton: 8801 49th Avenue, College Pk.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease [a], stating the underlying cause lost. (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		September 13, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 15, 1958		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	
22d. LOCATION (City, town, or county) Colmar Manor, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons			ADDRESS Hyattsville, Maryland.		
24a. REC'D BY REGISTRAR SEP 16 '58			24b. REGISTRAR'S SIGNATURE <i>Arthur L. Thomas</i>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Health Department or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Decedent's Name: John T. Williams, M.D.
Residence: 1015 North Avenue
Age: 58 Sex: M
Race: White Religion: Episcopal
Marital Status: Married Date of Birth: October 10, 1923
Place of Birth: Baltimore, Maryland

Occupation: Physician
Cause of Death: Myocardial infarction
Date of Death: September 10, 1980

Place of Death: Home
Signature of Medical Examiner: John T. Williams, M.D.
Signature of Coroner: John T. Williams, M.D.

Signature of Physician: John T. Williams, M.D.
Signature of Nurse: John T. Williams, M.D.

Signature of Pathologist: John T. Williams, M.D.
Signature of Forensic Examiner: John T. Williams, M.D.

Signature of Medical Examiner: John T. Williams, M.D.
Signature of Coroner: John T. Williams, M.D.

Signature of Physician: John T. Williams, M.D.
Signature of Nurse: John T. Williams, M.D.

Signature of Pathologist: John T. Williams, M.D.
Signature of Forensic Examiner: John T. Williams, M.D.

10466

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>41 Laurel</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Brooklyn Bridge Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>J.</u> Last <u>Burton</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>11</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 10 1872</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Burtonville Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Isaac Burton</u>		14. MOTHER'S MAIDEN NAME <u>EMMA Magedder</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Thomas Burton Jr.</u>		Address <u>Laurel, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Arteriosclerotic Heart Disease</u> DUE TO <u> </u> (c) <u>Longstanding Heart Failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2-3 yrs.</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1955</u> , 19 <u> </u> , to <u> </u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 10</u> , 19 <u>58</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert C Wingfield</u>		ADDRESS (Street, city or town, state) <u>311 Thomas Ave - Laurel Md.</u> DATE SIGNED <u>Sept 11, 1958</u>	
PHYSICIAN'S NAME (Type) <u>Robert C Wingfield</u>		M.D. <u> </u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 13, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Burtonville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Donaldson</u>		ADDRESS <u>Laurel Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 16 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10454

10467

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Raymond Middle Roy Last Chaney		4. DATE OF DEATH Month September Day 10, Year 1958	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4-24-1902
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Samuel Chaney	
14. MOTHER'S MAIDEN NAME Nellie Parker		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 220-32-6023		17. INFORMANT James J. Chaney; Address 7313 F. Street Carmody Hills	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		DATE SIGNED September 10, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/13/58	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons Hyattsville, Md.		24. REC'D BY REGISTRAR SEP 15 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John T. Talbot, Jr.	
Residence		New York City	
Age		35	
Sex		Male	
Race		White	
Date of Death		September 10, 1958	
Place of Death		New York City	
Cause of Death		Diphtheria	
Manner of Death		Natural	
Signature of Medical Examiner		[Signature]	
Signature of Coroner		[Signature]	
Signature of Physician		[Signature]	
Signature of Family Member		[Signature]	

10449

CERTIFICATE OF DEATH

10455

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Hyattsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> <u>15X-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carroll Manor</u> <u>4922 LaSalle Road</u>				d. STREET ADDRESS <u>4309 East West Highway</u>			
3. NAME OF DECEASED (Type or print) First <u>DAVID</u> Middle <u>HARVARD</u> Last <u>CHRISTENSEN</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>22</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 17, 1934</u>	9. AGE (In years last birthday) <u>23</u> yrs.	IF UNDER 1 YEAR Months <u>9</u> Days <u>5</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>College</u>		11. BIRTHPLACE (State or foreign country) <u>Mass</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>David H. Christensen</u>				14. MOTHER'S MAIDEN NAME <u>Genevieve Brogan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>579-48-2515</u>		17. INFORMANT <u>David H. Christensen, father—same as 2d</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left Ventricular failure</u> DUE TO <u>178X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Carcinomatosis -</u> DUE TO <u>Chronic Epithelioma of Testicle -</u> (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Carcinoma of Testicle -</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Wesley Bldg.</u>	
				20f. (City or town) <u>Bethesda, Md.</u>		(County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>58</u> , to <u>Sept 21</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 20</u> , 19 <u>58</u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. A. Martinez</u> M.D.				DATE SIGNED <u>Sept 21, 1958</u>			
PHYSICIAN'S NAME (Type) <u>F A Martinez</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/25/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		22d. LOCATION (City, town, or county) (State) <u>Silver Spring, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>SEP 23 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18
Item 2 Film 234 9-29-58 et
10524
CERTIFICATE OF DEATH

10456

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE D. C. MARYLAND b. COUNTY PRINCE GEORGE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORESTVILLE				c. LENGTH OF STAY IN 1b 4 YRS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FORESTVILLE NURSING HOME				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HARRY LAWRENCE CLARK				4. DATE OF DEATH SEPT. 18TH 1958			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 16-1874	
9. AGE (In years last birthday) 84 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FIREMAN		10b. KIND OF BUSINESS OR INDUSTRY RET. D.C.F.D.		11. BIRTHPLACE (State or foreign country) WASH. D. C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME HENRY L. CLARK		14. MOTHER'S MAIDEN NAME MARY L. SEARS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) YES SPANISH AMER		16. SOCIAL SECURITY NO. NONE		17. INFORMANT HARRY L. CLARK JR Address RED 4 BX 444 MCLEAN VA			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral-vascular accident - 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 331X DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congestive Heart Failure - Arteriosclerotic Heart Disease							INTERVAL BETWEEN ONSET AND DEATH 9-13-58-948
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-9-55 , 19___, to 9-18-58 , 19___, that I last saw the deceased alive on 9-17-58 , 19___, and that death occurred at 9:23 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Lawrence D. Summerfield				ADDRESS (Street, city or town, state) 1400 Branch Ave. S.E.			
PHYSICIAN'S NAME (Type) LAWRENCE D. SUMMERFIELD				DATE SIGNED 20, D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
BURIAL		9/20/58		CEDAR HILL		SCITLAND MD	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers				24a. REC'D BY REGISTRAR SEP 22 '58		24b. REGISTRAR'S SIGNATURE Orlinda E. Kline	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10468

CERTIFICATE OF DEATH

Reg. Dist. No.

10457

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Laurel General Hospital				d. STREET ADDRESS Route 100 Box 111			
3. NAME OF DECEASED (Type or print) First Iona Middle Conrad Last Conrad				4. DATE OF DEATH Month Sept. Day 27 Year 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 20, 1902	9. AGE (In years lost birthday) 56 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME William G. Larmour				14. MOTHER'S MAIDEN NAME Ella Hall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. -		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Pancreas 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 4/13 19 56 to 9/27 19 58 , that I last saw the deceased alive on 9/27/58 , 19 58 , and that death occurred at 11:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE J. M. Warren M.D.							
PHYSICIAN'S NAME (Type) J. M. Warren, M.D.				305 Prince George Street, Laurel, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-27-58	22c. NAME OF CEMETERY OR CREMATORY Balto. Cem	22d. LOCATION (City, town, or county) (State) Baltimore, Md				
23. FUNERAL DIRECTOR'S SIGNATURE Mc Call Funeral Home ADDRESS 1300 E. Falmere				24a. REC'D BY REGISTRAR DATE OCT 1 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10458

Reg. Dist. No.

10469

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eugene Leland Memorial Hospital				e. STREET ADDRESS 4314 Rowalt Drive Apt. #101			
3. NAME OF DECEASED (Type or print) First MINERVA Middle JANE Last CORT				4. DATE OF DEATH Month September Day 16 Year 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-30-65	9. AGE (In years lost birthday) 93 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Iowa	
13. FATHER'S NAME Albert Cort				14. MOTHER'S MAIDEN NAME Maria Eisman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Niece	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X Cerebral Thrombosis DUE TO General arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)				INTERVAL BETWEEN ONSET AND DEATH 8 days undetermined et.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Sept. 16, 1958, to Sept. 16, 1958, that I last saw the deceased alive on Sept. 16, 1958, and that death occurred at 2:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE L. W. Malin				ADDRESS (Street, city or town, state) Riverdale, Md.			
PHYSICIAN'S NAME (Type) L. W. Malin				DATE SIGNED 9-16-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/16/58		22c. NAME OF CEMETERY OR CREMATORY Harmony Reformed Ch.		22d. LOCATION (City, town, or county) (State) Zwingle, Iowa	
23. FUNERAL DIRECTOR'S SIGNATURE S. H. Hines Co., Washington, D.C.				24a. REC'D BY REGISTRAR DATE SEP 18 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PART I - DEATH		PART II - CAUSE OF DEATH	
1. Name of deceased: <u>John Doe</u>		2. Date of death: <u>10/15/1968</u>	
3. Sex: <u>Male</u>		4. Age: <u>45</u>	
5. Race: <u>White</u>		6. Marital status: <u>Married</u>	
7. Usual residence: <u>123 Main St, Baltimore, MD</u>		8. Place of death: <u>Home</u>	
9. Date of birth: <u>10/15/1923</u>		10. Date of death: <u>10/15/1968</u>	
11. Cause of death: <u>Myocardial infarction</u>		12. Immediate cause: <u>Coronary artery disease</u>	
13. Contributing cause: <u>None</u>		14. Underlying cause: <u>None</u>	
15. Manner of death: <u>Natural</u>		16. Physician's signature: <u>[Signature]</u>	
17. Date of death: <u>10/15/1968</u>		18. Date of certificate: <u>10/15/1968</u>	
19. Registrar's signature: <u>[Signature]</u>		20. Registrar's name: <u>[Name]</u>	
21. Date of registration: <u>10/15/1968</u>		22. Date of filing: <u>10/15/1968</u>	
23. Date of death: <u>10/15/1968</u>		24. Date of death: <u>10/15/1968</u>	
25. Date of death: <u>10/15/1968</u>		26. Date of death: <u>10/15/1968</u>	
27. Date of death: <u>10/15/1968</u>		28. Date of death: <u>10/15/1968</u>	
29. Date of death: <u>10/15/1968</u>		30. Date of death: <u>10/15/1968</u>	
31. Date of death: <u>10/15/1968</u>		32. Date of death: <u>10/15/1968</u>	
33. Date of death: <u>10/15/1968</u>		34. Date of death: <u>10/15/1968</u>	
35. Date of death: <u>10/15/1968</u>		36. Date of death: <u>10/15/1968</u>	
37. Date of death: <u>10/15/1968</u>		38. Date of death: <u>10/15/1968</u>	
39. Date of death: <u>10/15/1968</u>		40. Date of death: <u>10/15/1968</u>	
41. Date of death: <u>10/15/1968</u>		42. Date of death: <u>10/15/1968</u>	
43. Date of death: <u>10/15/1968</u>		44. Date of death: <u>10/15/1968</u>	
45. Date of death: <u>10/15/1968</u>		46. Date of death: <u>10/15/1968</u>	
47. Date of death: <u>10/15/1968</u>		48. Date of death: <u>10/15/1968</u>	
49. Date of death: <u>10/15/1968</u>		50. Date of death: <u>10/15/1968</u>	
51. Date of death: <u>10/15/1968</u>		52. Date of death: <u>10/15/1968</u>	
53. Date of death: <u>10/15/1968</u>		54. Date of death: <u>10/15/1968</u>	
55. Date of death: <u>10/15/1968</u>		56. Date of death: <u>10/15/1968</u>	
57. Date of death: <u>10/15/1968</u>		58. Date of death: <u>10/15/1968</u>	
59. Date of death: <u>10/15/1968</u>		60. Date of death: <u>10/15/1968</u>	
61. Date of death: <u>10/15/1968</u>		62. Date of death: <u>10/15/1968</u>	
63. Date of death: <u>10/15/1968</u>		64. Date of death: <u>10/15/1968</u>	
65. Date of death: <u>10/15/1968</u>		66. Date of death: <u>10/15/1968</u>	
67. Date of death: <u>10/15/1968</u>		68. Date of death: <u>10/15/1968</u>	
69. Date of death: <u>10/15/1968</u>		70. Date of death: <u>10/15/1968</u>	
71. Date of death: <u>10/15/1968</u>		72. Date of death: <u>10/15/1968</u>	
73. Date of death: <u>10/15/1968</u>		74. Date of death: <u>10/15/1968</u>	
75. Date of death: <u>10/15/1968</u>		76. Date of death: <u>10/15/1968</u>	
77. Date of death: <u>10/15/1968</u>		78. Date of death: <u>10/15/1968</u>	
79. Date of death: <u>10/15/1968</u>		80. Date of death: <u>10/15/1968</u>	
81. Date of death: <u>10/15/1968</u>		82. Date of death: <u>10/15/1968</u>	
83. Date of death: <u>10/15/1968</u>		84. Date of death: <u>10/15/1968</u>	
85. Date of death: <u>10/15/1968</u>		86. Date of death: <u>10/15/1968</u>	
87. Date of death: <u>10/15/1968</u>		88. Date of death: <u>10/15/1968</u>	
89. Date of death: <u>10/15/1968</u>		90. Date of death: <u>10/15/1968</u>	
91. Date of death: <u>10/15/1968</u>		92. Date of death: <u>10/15/1968</u>	
93. Date of death: <u>10/15/1968</u>		94. Date of death: <u>10/15/1968</u>	
95. Date of death: <u>10/15/1968</u>		96. Date of death: <u>10/15/1968</u>	
97. Date of death: <u>10/15/1968</u>		98. Date of death: <u>10/15/1968</u>	
99. Date of death: <u>10/15/1968</u>		100. Date of death: <u>10/15/1968</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film 233 9-18-58 et

CERTIFICATE OF DEATH

10459

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGE MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>	c. LENGTH OF STAY IN 1b <u>20 YRS.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 HYATTSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4004-QUEENSBURY RD (Private home)</u>		d. STREET ADDRESS <u>4004-QUEENSBURY RD.</u>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>C.</u> Last <u>DANIELS SR.</u>		4. DATE OF DEATH Month <u>9-</u> Day <u>8</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 9TH 1906</u>
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED POLICEMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MET-POLICEMAN</u>	
11. BIRTHPLACE (State or foreign country) <u>ENGLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HERAY J. DANIELS</u>		14. MOTHER'S MAIDEN NAME <u>FLOSSIE A.E. BARNEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>218-38-8595</u>	
17. INFORMANT <u>MARY DANIELS</u>		Address <u>4004-QUEENSBURY RD. HYATTSVILLE MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Arteriosclerosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<u>Chronic Myocardial Insufficiency</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-4</u> , 19 <u>48</u> , to <u>9-8</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9-6</u> , 19 <u>58</u> , and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. Deitz</u>		DATE SIGNED <u>9-8-58</u>	
PHYSICIAN'S NAME (Type) <u>A. Deitz M.D.</u>		ADDRESS (Street, city or town, state) <u>Hyattsville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9-11-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN</u>		22d. LOCATION (City, town, or county) (State) <u>BLADENSBURG MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Timothy Haulow</u>		ADDRESS <u>3831-GA. AVE. N.W.</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 15 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10461

10470

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheserly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital			d. STREET ADDRESS 7114 Claymore Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Wilbur Middle Chamberlain Last Davis			4. DATE OF DEATH Month Sept. Day 5 Year 58		
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 19, 1952		9. AGE (in years last birthday) 5 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Dist. of Columbia		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME Wilbur C. Davis; Sr.			14. MOTHER'S MAIDEN NAME Ruth Drake		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Wilbur C Davis; same address as # 2.		17. INFORMANT Wilbur C Davis; same address as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO (b) Drowning Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Drowned in bathtub			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 9-5- p. m. 19 58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home	
20f. (City or town) Hyattsville, Pr. Geo. Md.		20g. (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John T. Maloney</i>		EXAMINER'S NAME (Type) John T. Maloney, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED Sept. 5, 1958	
22a. BURIAL, CREMATION, or other disposition (Specify) Cremation		22b. DATE THEREOF 9/6/58		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory	
22d. LOCATION (City, town, or county) Colmar Manor Pr. Geo. Md.		22e. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Md.			24a. REC'D BY REGISTRAR DATE SEP 9 '58		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

PLACE FOR DEATH
CERTIFICATE

James George

James George

Fevers

D.O.B.

Lebanon

James George - General Hospital

James George - General Hospital

White

Chapman

White

White

James George

Lebanon

Lebanon

James George; age 7

James George

James George; age 7

Lebanon

Lebanon

James George

Lebanon

John T. Haines, M.D.

James George

James George

James George

James George

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10471

CERTIFICATE OF DEATH

10462

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General		d. STREET ADDRESS 5508 44th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Alice First Christie Middle Degees Last		4. DATE OF DEATH 9 Month 15 Day 1958 Year			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-8-85	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Washington D.C.	
13. FATHER'S NAME James Goddard		14. MOTHER'S MAIDEN NAME -		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Primary carcinoma of the Tail of the Pancreas DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-5 , 1958 , to 9-15 , 1958 , that I last saw the deceased alive on 9-14 , 1958 , and that death occurred at 10:15 AM , from the causes and on the date stated above.					
ACTUAL SIGNATURE R.D. BAKER M.D.		ADDRESS (Street, city or town, state) 2513 Buck Lodge Rd.		DATE SIGNED 9/15/58	
PHYSICIAN'S NAME (Type) R.D. BAKER, M.D.		Adelphi, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 18, 1958		22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery	
22d. LOCATION (City, town, or county) Washington D. C.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE F Gasch's Sons		ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE SEP 19 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Krawe	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 FilmG235 10-21-58 et

10472

CERTIFICATE OF DEATH

10463

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>8 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale 25</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General</u>				d. STREET ADDRESS <u>4905 Madison Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <u>Marie</u> Middle <u>Theresa</u> Last <u>Dinan</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>16</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1882</u> <u>10-2-1883</u>		9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>George Clark</u>				14. MOTHER'S MAIDEN NAME <u>Eva Schmidt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Evelyn Rooney Riverdale, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>chronic congestive heart failure</u> DUE TO <u>hypertension and arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>heart disease</u> DUE TO (c) <u>heart disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>several months</u> <u>years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x</u> <u>no beta mellen</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 9</u> , 19 <u>58</u> , to <u>Sept 16</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 15</u> , 19 <u>58</u> , and that death occurred at <u>12:25A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>T. L. Bergman</u>				ADDRESS (Street, city or town, state) <u>Hyattsville Md.</u> DATE SIGNED <u>Sept 16, 1958</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Till Bergman</u>				<u>Hyattsville, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 19, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Solmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 23 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

CERTIFICATE OF DEATH

1918

THE DEPT. OF HEALTH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		35		Jan 1, 1883		St. Louis, Mo.	
Cause of Death		Disease		Symptoms		Duration		Time of Day	
Pneumonia		Pneumonia		Cough, fever, etc.		10 days		10:00 AM	
Place of Death		Occupation		Education		Marital Status		Religion	
St. Louis, Mo.		Clerk		High School		Married		Catholic	
Signature of Physician		Signature of Registrar		Signature of Witness		Signature of Deceased		Signature of Family	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Death		Time of Death		Place of Death		Cause of Death		Disease	
Jan 15, 1918		10:00 AM		St. Louis, Mo.		Pneumonia		Pneumonia	
Signature of Physician		Signature of Registrar		Signature of Witness		Signature of Deceased		Signature of Family	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

10473

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 13 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X University Park d. STREET ADDRESS 4310 VanBuren St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ida Middle E. Last Dodson			4. DATE OF DEATH Month Sept Day 16 Year 1958				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 25, 1879	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A		
13. FATHER'S NAME Joseph Daniels			14. MOTHER'S MAIDEN NAME Elizabeth Burkard				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	17. INFORMANT James E. Dodson Address University Park, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dissecting Thoracic Aneurysm 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Brachiocephalic (c)					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 4-4 , 19 50 , to Sept 16 , 19 58 , that I last saw the deceased alive on 9-15 , 19 58 , and that death occurred at 8:25 A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hyattsville, Md. DATE SIGNED 9-16-58 ACTUAL SIGNATURE Dr. Aaron Deitz M.D. Hyattsville, Md. PHYSICIAN'S NAME (Type) Dr. Aaron Deitz							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept 18, 1958	22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery	22d. LOCATION (City, town, or county) (State) Washington D. C.				
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Md.			24a. REC'D BY REGISTRAR DATE SEP 23 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
CERTIFICATE OF DEATH

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10474

CERTIFICATE OF DEATH

Reg. Dist. No. 10465

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Anne A rundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Laurel General Hospital</u>				d. STREET ADDRESS <u>02x-2</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Robert Irvin Duvall</u>				4. DATE OF DEATH Month Day Year <u>Sept 15 1958</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 13 1958</u>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>name</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>name</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Irvin Duvall</u>				14. MOTHER'S MAIDEN NAME <u>Betty Elizabeth Duvall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Father</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anorexia</u> <u>773.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Immaturity of lungs</u> DUE TO (c) <u>Resorption hyaline membranes</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>9-6</u> , 19 <u>58</u> , to <u>9-8</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9-7</u> , 19 <u>58</u> , and that death occurred at <u>5:00 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Hilda Fernandez</u> M.D. <u>305 Prince George St. Laurel, Md.</u>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 16, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Clarksville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Donaldson</u>				ADDRESS <u>Laurel, Md</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 19 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10525

CERTIFICATE OF DEATH

Reg. Dist. No. 10466

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Naomi</u> Middle <u>Huntt</u> Last <u>Early</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>11</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cav</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 23 1880</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George J.R. Huntt</u>				14. MOTHER'S MAIDEN NAME <u>Kansas Welch</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Richard B. Early, Brandywine, Md.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL Apoplexy</u> <u>593X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIO-SCLEROSIS</u> DUE TO (c) <u>NEPHRITIS</u> INTERVAL BETWEEN ONSET AND DEATH <u>Several years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>FEBRUARY 1937</u> to <u>SEPT 11, 1958</u> , that I last saw the deceased alive on <u>Sept 11</u> , 19 <u>58</u> , and that death occurred at <u>8:40 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Waldorf MD</u> DATE SIGNED <u>9-13-58</u> ACTUAL SIGNATURE <u>George Weber</u> M.D. <u>Waldorf MD</u> PHYSICIAN'S NAME (Type) <u>GEORGE WEBER</u> <u>WALDORF MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/15/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Rest</u>		22d. LOCATION (City, town, or county) (State) <u>La Plata, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Huntt Funeral Home, Waldorf, Md.</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>SEP 17 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

1962

<p>1. Name of deceased: George J. Hulse</p>	
<p>2. Date of death: April 18, 1962</p>	
<p>3. Place of death: Home</p>	
<p>4. Cause of death: Heart failure</p>	
<p>5. Manner of death: Natural</p>	
<p>6. Age at death: 78 years</p>	
<p>7. Sex: Male</p>	
<p>8. Race: White</p>	
<p>9. Birth date: April 18, 1884</p>	
<p>10. Birth place: Baltimore, Maryland</p>	
<p>11. Marital status: Married</p>	
<p>12. Occupation: Retired</p>	
<p>13. Signature of physician: [Signature]</p>	
<p>14. Signature of registrar: [Signature]</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10475

CERTIFICATE OF DEATH

Reg. Dist. No.

10467

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. LENGTH OF STAY IN 1b 10 minutes			
d. NAME OF HOSPITAL (If not in hospital, give street address) Eugene Deland Memorial Hospital				d. STREET ADDRESS 8902--60th Ave.			
3. NAME OF DECEASED (Type or print) ALLISON LAWTON ETCHELLS				4. DATE OF DEATH Month September Day 24th Year 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 28, 1904		9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electronic Tech.		10b. KIND OF BUSINESS OR INDUSTRY Naval Ordnance		11. BIRTHPLACE (State or foreign country) Germantown, Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Elwood W. Etschells				14. MOTHER'S MAIDEN NAME Caroline Manse			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give year or dates of service) None		16. SOCIAL SECURITY NO. 138-01-8534		17. INFORMANT Hazel G. Etschells, 8902--60th Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY THROMBOSIS 463x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PHLEBOTROMBOSIS - LOWER EXTREMITY DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 20 MIN. 2-3 wks?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) IV					
20c. TIME OF INJURY Hour <input type="checkbox"/> a. m. <input type="checkbox"/> p. m. Month, Day, Year 19 58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-10 , 19 58 to 9-24 , 19 58 , that I last saw the deceased alive on 9-22 , 19 58 , and that death occurred at 4 PA M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Rowland F. Wilkinson		M.D. 4404 GUSSENSBURY RD		ADDRESS (Street, city or town, state) Riverdale, Md.		DATE SIGNED 9-26-58	
PHYSICIAN'S NAME (Type) Rowland F. Wilkinson		SIGNATURE R. F. Wilkinson, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/27/1958		22c. NAME OF CEMETERY OR CREMATORY George Wash. Cem. Riggs		22d. LOCATION (City, town, or county) Rd. Extd. Hyattsville, Prince Georges Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.				ADDRESS Riverdale, Md.		24a. REC'D BY REGISTRAR SEP 29 '58	
				24b. REGISTRAR'S SIGNATURE Arthur L. House			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10468

10526

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Gee's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland				c. LENGTH OF STAY IN 1b 2 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suitland Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ELIZA BELLE FARIS				4. DATE OF DEATH Month Sept. Day 8th. Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 14- 1874	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Texas	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME James M. Blankenship				14. MOTHER'S MAIDEN NAME Amanda Dove			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Miss. Bess Faris		Address Same # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) 4 years						INTERVAL BETWEEN ONSET AND DEATH 6 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 1400 BRANCH AVE, S.E.				20g. (County) Gatesville, Texas		20h. (State) Gatesville, Texas	
21. I certify that I attended the deceased from 11-10-53 , 19____, to 9-8-58 , that I last saw the deceased alive on 9-8-58 , 19____, and that death occurred at 5:55 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE LAWRENCE D. SUMMERFIELD, M.D.				DATE SIGNED 1400 BRANCH AVE, S.E.			
PHYSICIAN'S NAME (Type) LAWRENCE D. SUMMERFIELD, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 11th 58		22c. NAME OF CEMETERY OR CREMATORY Gatesville Cemetery		22d. LOCATION (City, town, or county) (State) Gatesville, Texas	
23. FUNERAL DIRECTOR'S SIGNATURE Sennar Bros 1661-gd Hope Rd & E.				24a. REC'D BY REGISTRAR DATE SEP 10 '58		24b. REGISTRAR'S SIGNATURE Arthur S. House	

10476

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Glenn</u> Middle <u>Fleet</u> Last <u>Fleet</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>10</u> Year <u>19 58</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 24, 1958</u>		9. AGE (In years last birthday) <u>xxxx</u> Months <u>7</u> Days <u>17</u> Hours <u>xx</u> Min. <u>xx</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>		13. FATHER'S NAME <u>Alvin Fleet</u>		14. MOTHER'S MAIDEN NAME <u>Mary Porter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Mary Porter</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Right Lobar Pneumonia</u> <u>490X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 9</u> , 19 <u>58</u> , to <u>Sept 10</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept. 10</u> , 19 <u>58</u> , and that death occurred at <u>2:10 P.</u> M. from the causes and on the date stated above.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
ACTUAL SIGNATURE <u>John Perkins</u>		ADDRESS (Street, city or town, state) <u>5301 Hawthill St., Hyattsville Md.</u>		DATE SIGNED <u>9/11/58</u>			
PHYSICIAN'S NAME (Type) <u>Dr. John Perkins</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-13-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brooks Church</u>		22d. LOCATION (City, town, or county) (State) <u>Brandywine, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William J. Seward</u>		ADDRESS <u>4339 New 1 Pl</u>		24a. REC'D BY REGISTRAR <u>SEP 15 '58</u>		24b. REGISTRAR'S SIGNATURE <u>John S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10470

10477

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last Ford		4. DATE OF DEATH Month September Day 5 Year 19 58	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 1, 1958
9. AGE (In years last birthday) yrs. 5		10. IF UNDER 1 YEAR Months 5 Days 16 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Nelson H. Ford		14. MOTHER'S MAIDEN NAME Margaret L. Medley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Margaret L Ford		Address Address same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 DUE TO Atelose fasis Rk lung Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) Prematurity DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 1, 1958 , to September 5, 1958 , that I last saw the deceased alive on September 5, 1958 , and that death occurred at 2:15 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John W. Penning		ADDRESS (Street, city or town, state) 5301 Hawthorne St., Hyattsville, Md.	
PHYSICIAN'S NAME (Type) Dr. John W. Penning		DATE SIGNED 9/5/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 9/25/58	
22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital		22d. LOCATION (City, town, or county) (State) Cheverly, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr.		ADDRESS Administrator.	
24a. REC'D BY REGISTRAR SEP 30 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained, by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10073

<p>1. Name of deceased: <u>JOHN J. JONES</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>10-15-1890</u></p>		<p>4. Place of birth: <u>NEW YORK</u></p>	
<p>5. Date of death: <u>10-25-1960</u></p>		<p>6. Place of death: <u>HOME</u></p>	
<p>7. Cause of death: <u>HEART DISEASE</u></p>		<p>8. Manner of death: <u>NATURAL</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Name of hospital: <u>ST. JOSEPH'S HOSPITAL</u></p>		<p>12. Name of attending physician: <u>DR. J. H. SMITH</u></p>	
<p>13. Name of informant: <u>JOHN J. JONES</u></p>		<p>14. Address of informant: <u>123 MAIN ST.</u></p>	
<p>15. Name of informant: <u>JOHN J. JONES</u></p>		<p>16. Address of informant: <u>123 MAIN ST.</u></p>	
<p>17. Name of informant: <u>JOHN J. JONES</u></p>		<p>18. Address of informant: <u>123 MAIN ST.</u></p>	
<p>19. Name of informant: <u>JOHN J. JONES</u></p>		<p>20. Address of informant: <u>123 MAIN ST.</u></p>	
<p>21. Name of informant: <u>JOHN J. JONES</u></p>		<p>22. Address of informant: <u>123 MAIN ST.</u></p>	
<p>23. Name of informant: <u>JOHN J. JONES</u></p>		<p>24. Address of informant: <u>123 MAIN ST.</u></p>	
<p>25. Name of informant: <u>JOHN J. JONES</u></p>		<p>26. Address of informant: <u>123 MAIN ST.</u></p>	
<p>27. Name of informant: <u>JOHN J. JONES</u></p>		<p>28. Address of informant: <u>123 MAIN ST.</u></p>	
<p>29. Name of informant: <u>JOHN J. JONES</u></p>		<p>30. Address of informant: <u>123 MAIN ST.</u></p>	
<p>31. Name of informant: <u>JOHN J. JONES</u></p>		<p>32. Address of informant: <u>123 MAIN ST.</u></p>	
<p>33. Name of informant: <u>JOHN J. JONES</u></p>		<p>34. Address of informant: <u>123 MAIN ST.</u></p>	
<p>35. Name of informant: <u>JOHN J. JONES</u></p>		<p>36. Address of informant: <u>123 MAIN ST.</u></p>	
<p>37. Name of informant: <u>JOHN J. JONES</u></p>		<p>38. Address of informant: <u>123 MAIN ST.</u></p>	
<p>39. Name of informant: <u>JOHN J. JONES</u></p>		<p>40. Address of informant: <u>123 MAIN ST.</u></p>	
<p>41. Name of informant: <u>JOHN J. JONES</u></p>		<p>42. Address of informant: <u>123 MAIN ST.</u></p>	
<p>43. Name of informant: <u>JOHN J. JONES</u></p>		<p>44. Address of informant: <u>123 MAIN ST.</u></p>	
<p>45. Name of informant: <u>JOHN J. JONES</u></p>		<p>46. Address of informant: <u>123 MAIN ST.</u></p>	
<p>47. Name of informant: <u>JOHN J. JONES</u></p>		<p>48. Address of informant: <u>123 MAIN ST.</u></p>	
<p>49. Name of informant: <u>JOHN J. JONES</u></p>		<p>50. Address of informant: <u>123 MAIN ST.</u></p>	
<p>51. Name of informant: <u>JOHN J. JONES</u></p>		<p>52. Address of informant: <u>123 MAIN ST.</u></p>	
<p>53. Name of informant: <u>JOHN J. JONES</u></p>		<p>54. Address of informant: <u>123 MAIN ST.</u></p>	
<p>55. Name of informant: <u>JOHN J. JONES</u></p>		<p>56. Address of informant: <u>123 MAIN ST.</u></p>	
<p>57. Name of informant: <u>JOHN J. JONES</u></p>		<p>58. Address of informant: <u>123 MAIN ST.</u></p>	
<p>59. Name of informant: <u>JOHN J. JONES</u></p>		<p>60. Address of informant: <u>123 MAIN ST.</u></p>	
<p>61. Name of informant: <u>JOHN J. JONES</u></p>		<p>62. Address of informant: <u>123 MAIN ST.</u></p>	
<p>63. Name of informant: <u>JOHN J. JONES</u></p>		<p>64. Address of informant: <u>123 MAIN ST.</u></p>	
<p>65. Name of informant: <u>JOHN J. JONES</u></p>		<p>66. Address of informant: <u>123 MAIN ST.</u></p>	
<p>67. Name of informant: <u>JOHN J. JONES</u></p>		<p>68. Address of informant: <u>123 MAIN ST.</u></p>	
<p>69. Name of informant: <u>JOHN J. JONES</u></p>		<p>70. Address of informant: <u>123 MAIN ST.</u></p>	
<p>71. Name of informant: <u>JOHN J. JONES</u></p>		<p>72. Address of informant: <u>123 MAIN ST.</u></p>	
<p>73. Name of informant: <u>JOHN J. JONES</u></p>		<p>74. Address of informant: <u>123 MAIN ST.</u></p>	
<p>75. Name of informant: <u>JOHN J. JONES</u></p>		<p>76. Address of informant: <u>123 MAIN ST.</u></p>	
<p>77. Name of informant: <u>JOHN J. JONES</u></p>		<p>78. Address of informant: <u>123 MAIN ST.</u></p>	
<p>79. Name of informant: <u>JOHN J. JONES</u></p>		<p>80. Address of informant: <u>123 MAIN ST.</u></p>	
<p>81. Name of informant: <u>JOHN J. JONES</u></p>		<p>82. Address of informant: <u>123 MAIN ST.</u></p>	
<p>83. Name of informant: <u>JOHN J. JONES</u></p>		<p>84. Address of informant: <u>123 MAIN ST.</u></p>	
<p>85. Name of informant: <u>JOHN J. JONES</u></p>		<p>86. Address of informant: <u>123 MAIN ST.</u></p>	
<p>87. Name of informant: <u>JOHN J. JONES</u></p>		<p>88. Address of informant: <u>123 MAIN ST.</u></p>	
<p>89. Name of informant: <u>JOHN J. JONES</u></p>		<p>90. Address of informant: <u>123 MAIN ST.</u></p>	
<p>91. Name of informant: <u>JOHN J. JONES</u></p>		<p>92. Address of informant: <u>123 MAIN ST.</u></p>	
<p>93. Name of informant: <u>JOHN J. JONES</u></p>		<p>94. Address of informant: <u>123 MAIN ST.</u></p>	
<p>95. Name of informant: <u>JOHN J. JONES</u></p>		<p>96. Address of informant: <u>123 MAIN ST.</u></p>	
<p>97. Name of informant: <u>JOHN J. JONES</u></p>		<p>98. Address of informant: <u>123 MAIN ST.</u></p>	
<p>99. Name of informant: <u>JOHN J. JONES</u></p>		<p>100. Address of informant: <u>123 MAIN ST.</u></p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10471

10478

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b Dead on arrival		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Largo			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 8001 White House Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James Edward Fuller				4. DATE OF DEATH Month September Day 2 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	8. DATE OF BIRTH Dec. 16, 1871	9. AGE (in years last birthday) 86 yrs.	IF UNDER 1 YEAR Months 86 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Skilled laborer		10b. KIND OF BUSINESS OR INDUSTRY Lugage		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James William Fuller				14. MOTHER'S MAIDEN NAME Mary Owen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Address Mrs Della F. Birdsong same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd				DATE SIGNED September 3, 1958			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 4, 1958		22c. NAME OF CEMETERY OR CREMATORY Petersburg		22d. LOCATION (City, town, or county) (State) Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR SEP 5 58 DATE	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MISSISSIPPI STATE DEPARTMENT OF HEALTH - BIRMINGHAM 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Source of Infection: Contagious
Nature of Disease: Scarlet fever

September 3, 1918

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10472 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10472

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	c. LENGTH OF STAY IN 1b 1 1/2 hrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 5723 29th Avenue	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Mary Middle Scanlon Last Gaegler		4. DATE OF DEATH Month September Day 13 Year 19 58	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 19, 1926
9. AGE (In years last birthday) 32 yrs.		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't A.F.L. Washington	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Edward Aloysius Scanlon		14. MOTHER'S MAIDEN NAME Bernadette O'Connor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT Delores Ann Scanlon; sister. Washington, D.C.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 816X DUE TO Conditions, if any, which gave rise to immediate cause (b) Crushed chest (c) Crushed chest DUE TO (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Operator of an automobile in collision with a pick up truck.			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) Operator of an automobile in collision with a pick up truck.	
20c. TIME OF INJURY Month, Day, Year 5:00 p.m. 9-13-58	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	20f. (City or town) (County) (State) Near Large Pr. Geo. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED September 13, 1958	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/17/58	22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven	22d. LOCATION (City, town, or county) (State) Silver Spring Md.
23. FUNERAL DIRECTOR'S SIGNATURE Mr. Rainier, Md.		24a. REC'D BY REGISTRAR SEP 18 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by you. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

regional center.

2001 11

Figure 1

[illegible][illegible]

1998

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John M. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3, Film G234, 10/6/58 for

CERTIFICATE OF DEATH

Reg. Dist. No.

10473

10451

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE COUNTY</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>(Correct) PRINCE GEORGE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>				c. LENGTH OF STAY IN IB <u>10 mos.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 HYATTSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CARROLL MANOR</u>				d. STREET ADDRESS <u>1 4922 LASALLE RD.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WY First GUINETTE</u> <u>Middle BOONE</u> <u>Last GARDINER</u>				4. DATE OF DEATH Month <u>SEPT.</u> Day <u>22</u> Year <u>19 58</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/24/71</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NURSE</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>ST. MARY'S COUNTY, MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>ALFRED W. GARDINER</u>				14. MOTHER'S MAIDEN NAME <u>MARY ELLEN GWINN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Maude Gardiner Mechanicsville, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis c Myocardial infarct.</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes Mellitus</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1 year</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. _____ p. m. _____ Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>July 18</u> , 19 <u>58</u> , to <u>Sept. 22</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept. 21</u> , 19 <u>58</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Thomas F. Collins</u> M.D. <u>322 H St., N.E.</u> PHYSICIAN'S NAME (Type) <u>THOMAS F. COLLINS, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>9/25/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wash D.C.</u>		22d. LOCATION (City, town, or county) (State) <u>Wash D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gale A Mattingly</u>				ADDRESS <u>131-11 St. Wash D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 24 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kane</u>	

CERTIFICATE OF DEATH

20121

NAME OF DECEASED JOHN J. GARDNER		AGE 45		SEX Male		RACE White		DATE OF DEATH 10/15/1912		PLACE OF DEATH Home	
BIRTH 1867		DEATH 1912		CAUSE OF DEATH Myocardial Infarction		DISEASE Coronary Artery Disease		MANNER OF DEATH Natural		SIGNATURE OF DECEASED [Signature]	
FATHER'S NAME JAMES GARDNER		MOTHER'S NAME MARY GARDNER		BIRTH OF FATHER 1835		BIRTH OF MOTHER 1840		MARRIAGE 1885		EDUCATION High School	
OCCUPATION Mechanic		RESIDENCE 1234 Main St, Baltimore, MD		PREVIOUS ILLNESS None		TREATMENT None		HISTORY None		TESTIMONY None	
CERTIFICATE OF DEATH		STATE OF MARYLAND		COUNTY OF BALTIMORE		CITY OF BALTIMORE		WITNESSES [Signatures]		DOCTOR'S SIGNATURE [Signature]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10452

CERTIFICATE OF DEATH

Reg. Dist. No.

10474

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Hyattsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Hyattsville 15</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2012 Van Buren St.</u>		d. STREET ADDRESS <u>2012 Van Buren St.</u>	
3. NAME OF DECEASED (Type or print) First <u>DANIEL</u> Middle <u>GILLESPIE</u> Last <u>GILLESPIE</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>30</u> Year <u>1958</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 31 - 1957</u>
9. AGE (In years last birthday) yrs. <u>11</u>		IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min. <u>11</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>—</u>	
13. FATHER'S NAME <u>Thomas Gillespie</u>		14. MOTHER'S MAIDEN NAME <u>Ann Moran</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Thomas Gillespie</u>		Address <u>2012 Van Buren St</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> 344X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hydrocephalus, communicating type</u> DUE TO (c) <u>8 mos.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10/31, 1957</u> , to <u>9/30, 1958</u> , that I last saw the deceased alive on <u>9/26, 1958</u> , and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Louis L. Cross, M.D.</u>		ADDRESS (Street, city or town, state) <u>7028 Marlboro Pike, S.E., Washington 28, D.C.</u>	
PHYSICIAN'S NAME (Type) <u>Louis L. Cross, M.D.</u>		DATE SIGNED <u>—</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct 12 - 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>mt. Olivet</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Costello</u>		ADDRESS <u>1722 North Capitol</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10475
Reg. Dist. No.

10527

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Dist. of Col. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville		c. LENGTH OF STAY IN 1b transit	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S.Rt. 1 and O'Dell Rd.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
3. NAME OF DECEASED (Type or print) Leo Rafael Gonzales		4. DATE OF DEATH Month Sept. Day 8 Year 19 58	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-19-37
9. AGE (In years last birthday) 21 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		12. KIND OF BUSINESS OR INDUSTRY Air conditioning	
13. BIRTHPLACE (State or foreign country) Washington, D.C.		14. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. FATHER'S NAME Roland Gonzales, Sr.		16. MOTHER'S MAIDEN NAME Virginia Tolley	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		18. SOCIAL SECURITY NO.	
19. INFORMANT Roland Gonzales, Jr.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suffocation 822X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Compression of neck and chest DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of an automobile which overturned.	
20c. TIME OF INJURY Month, Day, Year Sept. 9-8- 19 58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) Beltsville, Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED September 8, 1958	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 11 1958	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln	22d. LOCATION (City, town, or county) (State) Prince George Md
23. FUNERAL DIRECTOR'S SIGNATURE Deaf Funeral Home		24a. REC'D BY REGISTRAR SEP 10 '58	
ADDRESS 4812 Ga Ave		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased: John J. [illegible]

Residence: [illegible]

Age: U.S. No. 1 and 1001 24

Sex: Male Race: White

Occupation: Police Officer

Usual Residence: [illegible]

Place of Death: [illegible]

Cause of Death: Compression of neck and chest

Duration: [illegible]

Time of Death: 11:00 P.M.

Date: Jan 24

Signature: [illegible]

Witness: [illegible]

Signature: [illegible]

Signature: [illegible]

Signature: [illegible]

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10476

10528

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Pr. Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SUITLAND</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SUITLAND</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4410-ARNOLD RD. SE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Roxie E. Graham</u>				4. DATE OF DEATH Month Day Year <u>Sept. 6 1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 20-1893</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>James R. Hastings</u>			
14. MOTHER'S MAIDEN NAME <u>Sarah E. Hitchens</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, specify or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Margaret E. Starkweather</u> Address <u>503 Kentucky Ave. S.E.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Congestive Heart Failure</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>15 yr.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb. 15, 1950</u> , to <u>Sept 6, 1958</u> , that I last saw the deceased alive on <u>Sept 5, 1958</u> , and that death occurred at <u>9:20 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank S. Pellegrini</u> M.D.				ADDRESS (Street, city or town, state) <u>3409 Ala Ave SE</u>			
PHYSICIAN'S NAME (Type) <u>FRANK S. PELLEGRINI</u>				DATE SIGNED <u>9.6.58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-8-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Natl.</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros.</u> ADDRESS <u>1661- Good Hope Rd SE Wash. DC</u>				24a. REC'D BY REGISTRAR <u>SEP 8 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kious</u>	

CERTIFICATE OF DEATH

10528

DECEASED'S NAME <i>Frank J. [illegible]</i>		SEX <i>Male</i>		AGE <i>45</i>	
DATE OF DEATH <i>April 2, 1950</i>		PLACE OF DEATH <i>Home</i>		CITY <i>St. Louis</i>	
COUNTY <i>St. Louis</i>		STATE <i>Missouri</i>		ZIP CODE <i>63101</i>	
DECEASED'S ADDRESS <i>1234 [illegible] St.</i>		DECEASED'S OCCUPATION <i>Teacher</i>		DECEASED'S MARITAL STATUS <i>Married</i>	
DECEASED'S BIRTH DATE <i>April 2, 1905</i>		DECEASED'S BIRTH PLACE <i>St. Louis, Mo.</i>		DECEASED'S RACE <i>White</i>	
DECEASED'S RELIGION <i>Catholic</i>		DECEASED'S EDUCATION <i>High School Graduate</i>		DECEASED'S SERVICE <i>None</i>	
DECEASED'S SOCIAL SECURITY NUMBER <i>[illegible]</i>		DECEASED'S MOTHER'S MAIDEN NAME <i>[illegible]</i>		DECEASED'S FATHER'S NAME <i>[illegible]</i>	
DECEASED'S MOTHER'S BIRTH DATE <i>[illegible]</i>		DECEASED'S MOTHER'S BIRTH PLACE <i>[illegible]</i>		DECEASED'S MOTHER'S RACE <i>[illegible]</i>	
DECEASED'S MOTHER'S RELIGION <i>[illegible]</i>		DECEASED'S MOTHER'S EDUCATION <i>[illegible]</i>		DECEASED'S MOTHER'S SERVICE <i>[illegible]</i>	
DECEASED'S MOTHER'S SOCIAL SECURITY NUMBER <i>[illegible]</i>		DECEASED'S MOTHER'S MOTHER'S MAIDEN NAME <i>[illegible]</i>		DECEASED'S MOTHER'S FATHER'S NAME <i>[illegible]</i>	
DECEASED'S MOTHER'S BIRTH DATE <i>[illegible]</i>		DECEASED'S MOTHER'S BIRTH PLACE <i>[illegible]</i>		DECEASED'S MOTHER'S RACE <i>[illegible]</i>	
DECEASED'S MOTHER'S RELIGION <i>[illegible]</i>		DECEASED'S MOTHER'S EDUCATION <i>[illegible]</i>		DECEASED'S MOTHER'S SERVICE <i>[illegible]</i>	
DECEASED'S MOTHER'S SOCIAL SECURITY NUMBER <i>[illegible]</i>		DECEASED'S MOTHER'S MOTHER'S MAIDEN NAME <i>[illegible]</i>		DECEASED'S MOTHER'S FATHER'S NAME <i>[illegible]</i>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE.

10529

CERTIFICATE OF DEATH

10477

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Prince George's County</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Seabrook Heights</i> c. LENGTH OF STAY IN 1b <i>13 days</i> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <i>MD</i> b. COUNTY <i>Prince George's</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Seabrook Heights</i> d. STREET ADDRESS <i>1601 Eastern Ave.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Antonie Therese Gray</i>		4. DATE OF DEATH Month <i>September</i> Day <i>27</i> Year <i>1958</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-5-1893</i>
9. AGE (In years last birthday) <i>65</i>		IF UNDER 1 YEAR Months <i>05</i> Days <i>05</i> Hours <i>00</i> Min. <i>00</i>	IF UNDER 24 HRS. Hours <i>00</i> Min. <i>00</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Wash. D.C.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Wash. D.C.</i>	
11. BIRTHPLACE (State or foreign country) <i>Wash. D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Chas Gray</i>		14. MOTHER'S MAIDEN NAME <i>Bonnie Hurlock</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>		16. SOCIAL SECURITY NO. <i>1578-42-408</i>	
17. INFORMANT <i>Archib Garry</i>		Address <i>1601 Eastern Ave</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4330</i> DUE TO <i>Complete heart block</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>arteriosclerotic calcification</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>3-15-55</i> to <i>9-27-58</i> , that I last saw the deceased alive on <i>9-25-58</i> , and that death occurred at <i>11:00 P.</i> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Richard Gitter</i> M.D.		DATE SIGNED <i>656 East Capitol St. Wash. D.C.</i>	
PHYSICIAN'S NAME (Type) <i>RICHARD GITTER</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>10/1/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Suitland Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons</i>		ADDRESS <i>Hyattsville Md.</i>	
24a. REC'D BY REGISTRAR DATE <i>SEP 30 '58</i>		24b. REGISTRAR'S SIGNATURE <i>William L. Haines</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK
JAMES BOEHLER

CERTIFICATE OF DEATH

1923

MARY AND STATE DEPARTMENT OF HEALTH - BATHONE 16

Name of Deceased		Date of Death	
Mary		1923	
Age		Sex	
10		Female	
Place of Birth		Cause of Death	
New York		Diphtheria	
Occupation		Duration of Illness	
None		10 days	
Signature of Physician		Signature of Registrar	
J. M. Smith		J. M. Smith	
Date of Certificate		Place of Death	
1923		New York	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10478

10530

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5711--St. Barnabas Rd. SE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First KATIE Middle V. Last GRIMES		4. DATE OF DEATH Month Sept. Day 25 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 11, 1881
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U. S. Gov't.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Grimes		14. MOTHER'S MAIDEN NAME Catherine A. Baden	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Eva M. Sydnor		Address 5811--St. Barnabas Rd., S.E.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO coronary occlusion (b) generalized atherosclerosis (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hours 20 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1956, to 9/25, 1958, that I last saw the deceased alive on 9/18, 1958, and that death occurred at M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE James T. Burns M.D. 915--19th St., N. W., Wash. D. C. 9-25-58 PHYSICIAN'S NAME (Type) James T. Burns 915--19th St., N. W., Washington, DC			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Sept 29-58	
22c. NAME OF CEMETERY OR CREMATORY St Barnabas		22d. LOCATION (City, town, or county) (State) Oxon Hill, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros 1661- 9th Hager Rd SE Walt 20 DC		24a. REC'D BY REGISTRAR DATE SEP 29 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10531

CERTIFICATE OF DEATH

Reg. Dist. No. 10479

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D. C.</u> b. COUNTY <u>-</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale (rural)</u>				c. LENGTH OF STAY IN 1b <u>1 month and 5 days</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>				47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glenn Dale Hospital</u>				d. STREET ADDRESS <u>2617 Garfield St., N. W.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>M.</u> Last <u>Gunther</u>				4. DATE OF DEATH Month <u>9</u> Day <u>2</u> Year <u>19 58</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/15/94</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u>		IF UNDER 24 HRS. Hours <u>-</u> Min. <u>-</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Stewart J. Smith</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Spicer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Decedent</u>		Address <u>-</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary tuberculosis</u> <u>002X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>-</u> DUE TO (c) <u>-</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary emphysema and cor pulmonale</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/28/</u> , 19 <u>58</u> , to <u>9/2/</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9/2/</u> , 19 <u>58</u> , and that death occurred at <u>9:00A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Moe Weiss</u>				ADDRESS (Street, city or town, state) <u>Glenn Dale Hospital</u>			
DATE SIGNED <u>9/2/58</u>							
PHYSICIAN'S NAME (Type) <u>Moe Weiss, M. D.</u>				<u>Glenn Dale, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>9/2/58</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Gaulliere</u>				ADDRESS <u>1752 Pa. Ave. NW</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 5 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

CERTIFICATE OF DEATH

10581

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JAN 15 1941	
AGE		SEX	
65		M	
RACE		EDUCATION	
W		H	
BIRTH DATE		BIRTH PLACE	
JAN 15 1876		BALTIMORE, MD	
MARRIAGE DATE		MARRIAGE PLACE	
JAN 15 1900		BALTIMORE, MD	
OCCUPATION		CAUSE OF DEATH	
Carpenter		Heart Disease	
PREVIOUS ILLNESS		MANNER OF DEATH	
None		Natural	
PLACE OF DEATH		RESIDENT	
Home		Yes	
HOSPITAL		NATURAL DEATH	
None		YES	
DATE OF BURIAL		PLACE OF BURIAL	
JAN 17 1941		BALTIMORE, MD	
CEREMONY		CITY OF BALTIMORE	
None		YES	
DATE OF INTERMENT		PLACE OF INTERMENT	
JAN 17 1941		BALTIMORE, MD	
CEREMONY		CITY OF BALTIMORE	
None		YES	

RECEIVED
JAN 16 1941
BALTIMORE, MD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10480

10480

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Judith Florence Haga		4. DATE OF DEATH Month Day Year September 1, 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 20, 1945
9. AGE (In years last birthday) 13 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Girl		10b. KIND OF BUSINESS OR INDUSTRY West Virginia	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Virginia Louise Haga	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Ray Haga		Address Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxia 850X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Drowning DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Drowned while (in swimming) floating on a raft which overturned	
20c. TIME OF INJURY Month, Day, Year 5.50 p.m. Sept. 1 19 58	20d. INJURY OCCURRED <input checked="" type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Clay pit.	20f. (City or town) (County) (State) Laurel Pr. Geo. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , (inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED Sept. 1, 1958	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept 4 1958	22c. NAME OF CEMETERY OR CREMATORY Long Hill Cem.	22d. LOCATION (City, town, or county) (State) Laurel Md.
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Kraus		24a. REC'D BY REGISTRAR SEP 5 58	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John T. Johnson, M.D.		Male		35	
Date of Death		Place of Death		Cause of Death	
Sept. 1, 1955		Home		Myocardial Infarction	
Time of Death		Manner of Death		Occupation	
10:00 AM		Natural		Physician	
Signature of Examiner		Signature of Coroner		Signature of Registrar	
[Signature]		[Signature]		[Signature]	
Date of Report		Place of Report		Cause of Report	
Sept. 1, 1955		Home		Myocardial Infarction	
Time of Report		Manner of Report		Occupation	
10:00 AM		Natural		Physician	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10481

Reg. Dist. No.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u> c. LENGTH OF STAY IN 1b <u>Readon ave</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hosp</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Spaulding Heights</u> d. STREET ADDRESS <u>1600-6221 Place</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Catherine Lydia Harbin</u> First Middle Last 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Feb 17, 1908</u> 9. AGE (In years last birthday) <u>50</u> yrs.		4. DATE OF DEATH Month <u>Sept</u> Day <u>25</u> Year <u>1958</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Horsewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Gun Home</u> 11. BIRTHPLACE (State or foreign country) <u>West Virginia</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.C</u>	
13. FATHER'S NAME <u>John Custer</u> 14. MOTHER'S MAIDEN NAME <u>Unknown</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>William E. Harbin Jr, same as #</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X Congestive heart failure</u> DUE TO (b) <u>Cardiorenal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D. EXAMINER'S NAME (Type) <u>JAMES I. Boyd</u> 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>9/29/58</u> 22c. NAME OF CEMETERY OR CREMATOR <u>Arlington National</u> 22d. LOCATION (City, town, or county) <u>Arlington Va.</u> (State) _____		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Sept 26, 1958</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville Md.</u> 24a. REC'D BY REGISTRAR <u>SEP 30 '58</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

NEW STATE
HEALTH DEPT



STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
NEW YORK

DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
NEW YORK

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10482

CERTIFICATE OF DEATH

Reg. Dist. No. 10482

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u> <u>Prince George</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Hazelton</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>13</u> Year <u>19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 12 1958</u>		9. AGE (In years last birthday) yrs. <u>1</u> Months <u>1</u> Days <u>9</u> Hours <u>9</u> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newborn</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Hazelton</u>				14. MOTHER'S MAIDEN NAME <u>Ruth Cross</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776x Premature</u> DUE TO <u>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</u> (b) <u>DUE TO</u> (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Sept 12</u> , 19 <u>58</u> , to <u>Sept 13</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 13</u> , 19 <u>58</u> , and that death occurred at <u>5:00P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. Kennedy Skipton</u> M.D.		ADDRESS (Street, city or town, state) <u>7220 Forest Rd.</u>		DATE SIGNED <u>9-14-58</u>			
PHYSICIAN'S NAME (Type) <u>Dr. R. Kennedy Skipton</u>		<u>Rent Village, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>9-15-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>DC</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Imad Haulon</u>		ADDRESS <u>3531 Ga. Ave NW</u>		24a. REC'D BY REGISTRAR <u>SEP 18 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanks</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10483

CERTIFICATE OF DEATH

Reg. Dist. No.

10483

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Herbert Last Herbert		4. DATE OF DEATH Month Sept. Day 6 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 18 Aug. 1894
9. AGE (In years last birthday) yrs. 64		10. IF UNDER 1 YEAR Months 6 Days 19 Hours 58	
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Electrical Engineer		10b. KIND OF BUSINESS OR INDUSTRY Government	
11. BIRTHPLACE (State or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Walter Herbert		14. MOTHER'S MAIDEN NAME Clara Eugene Egan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give year or dates of service) WWI		16. SOCIAL SECURITY NO. 214-36-2722	
17. INFORMANT Hilda B. Herbert		Address Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Perforation of the rectum DUE TO (c) Adeno carcinoma of rectum		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/2 , 19 58 , to 9/5 , 19 58 , that I last saw the deceased alive on 9/4/58 , 19 58 , and that death occurred at 4:05 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Gordon W. Kelley		ADDRESS (Street, city or town, state) DATE SIGNED 6124-41st Ave. Hyattsville, Md. 9/5/58	
PHYSICIAN'S NAME (Type) Dr. Gordon Kelley., M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/9/58	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Zosch's Sons		ADDRESS 4739 Balto. Ave. Hyattsville, Md.	
24. REG. BY REGISTRAR SEP 9 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10484

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Janet Middle Roberta Last Hicks		4. DATE OF DEATH Month September Day 1 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 7, 1943
9. AGE (In years last birthday) 15 yrs.		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Girl		10b. KIND OF BUSINESS OR INDUSTRY West Virginia	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Hicks		14. MOTHER'S MAIDEN NAME Vannie Marie Canady	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. None	
17. INFORMANT James Robert Hicks		Address Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 850 X DUE TO Conditions, if any, which gave rise to immediate cause (b) Drowning (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Drowned while swimming.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) floating on a raft which overturned.	
20c. TIME OF INJURY Month, Day, Year 5.50 Sept 1, 1958 Hour xx p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Clay pit		20f. (City or town) (County) (State) Laurel Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John J. Maloney		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		September 1, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 4, 1958	
22c. NAME OF CEMETERY OR CREMATORY St. Mary's Hill Cem.		22d. LOCATION (City, town, or county) (State) Laurel Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Kraus		24a. REC'D BY REGISTRAR DATE SEP 5 '58	
ADDRESS Arthur S. Kraus		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NO. 12-11-12

County of Baltimore
City of Baltimore
Name of Deceased
John T. Williams
Age
35
Sex
Male
Race
White
Date of Death
December 1, 1920
Place of Death
Home
Cause of Death
Disease of the heart
Died at
Home
Signature of Medical Examiner
J. H. Williams
Signature of Coroner
J. H. Williams
Signature of Physician
J. H. Williams

County of Baltimore
City of Baltimore
Name of Deceased
John T. Williams
Age
35
Sex
Male
Race
White
Date of Death
December 1, 1920
Place of Death
Home
Cause of Death
Disease of the heart
Died at
Home
Signature of Medical Examiner
J. H. Williams
Signature of Coroner
J. H. Williams
Signature of Physician
J. H. Williams

Signature of Medical Examiner
J. H. Williams
Signature of Coroner
J. H. Williams
Signature of Physician
J. H. Williams
Date of Death
December 1, 1920
Place of Death
Home
Cause of Death
Disease of the heart
Died at
Home
Signature of Medical Examiner
J. H. Williams
Signature of Coroner
J. H. Williams
Signature of Physician
J. H. Williams

10485

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL		c. LENGTH OF STAY IN 1b adm. 9-27-1948 X UPPER MARLBORO		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LAUREL SANITARIUM				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ELLEN H. HILL				4. DATE OF DEATH Month September Day 22 Year 1958			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 5 1876	9. AGE (In years last birthday) 82	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WILLIAM H. HARPER				14. MOTHER'S MAIDEN NAME Elizabeth Mullikin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address HOSPITAL RECORDS LAUREL SANITARIUM			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia (aspiration) 491 DUE TO 334 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) right hemiplegia DUE TO 334 (c) cerebral arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 3 days 22 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X arteriosclerotic cardio-vascular disease							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from June 7 - 1956 , to Sept - 22 - 1958 , that I last saw the deceased alive on Sept - 22 - 1958 , and that death occurred at 9:55 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Erika P. Kraemer				ADDRESS (Street, city or town, state) LAUREL SANITARIUM DATE SIGNED 9-22-58			
PHYSICIAN'S NAME (Type) ERIKA P. KRAEMER				LAUREL MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 9/25/58		22c. NAME OF CEMETERY OR CREMATORY Trinity Cemetery		22d. LOCATION (City, town, or county) (State) Upper Marlboro, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Catholic Bros. Upper Marlboro, Md.				24a. REC'D BY REGISTRAR DATE SEP 26 '58		24b. REGISTRAR'S SIGNATURE Carlton S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1922

NAME OF DECEASED JAMES J. HARRIS		AGE 45		SEX Male		RACE White	
DATE OF DEATH April 15, 1922		PLACE OF DEATH Home		CITY Boston		COUNTY Suffolk	
CAUSE OF DEATH Myocardial Infarction		DURATION OF ILLNESS 2 weeks		NATURE OF ILLNESS Coronary Artery Disease		PREVIOUS ILLNESS None	
TIME OF DEATH 10:30 AM		PLACE OF BURIAL Catholic Cemetery		CITY Boston		COUNTY Suffolk	
SIGNATURE OF PHYSICIAN J. J. Harrington		SIGNATURE OF CLERK J. J. Harrington		SIGNATURE OF DECEASED J. J. Harrington		SIGNATURE OF WITNESSES J. J. Harrington	
DATE OF SIGNATURE April 15, 1922		DATE OF SIGNATURE April 15, 1922		DATE OF SIGNATURE April 15, 1922		DATE OF SIGNATURE April 15, 1922	



10532

CERTIFICATE OF DEATH

10486

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCES GEORGES, MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>PENNSYLVANIA</u> b. COUNTY <u>LANCASTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANDREWS AFB</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>East Petersburg 75X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>USAF HOSPITAL ANDREWS</u>				d. STREET ADDRESS <u>none</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JAY</u> Middle <u>KEVIN</u> Last <u>HOLLINGER</u>				4. DATE OF DEATH Month <u>SEP</u> Day <u>29</u> Year <u>1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>CAU</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEP 29, 1958</u>	
9. AGE (In years last birthday) <u>—</u> yrs.		IF UNDER 1 YEAR: Months <u>—</u> Days <u>—</u> Hours <u>15</u> Min. <u>38</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>N/A</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N/A</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>GERALD S. HOLLINGER</u>		14. MOTHER'S MAIDEN NAME <u>JEAN FORNEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>N/A</u>		16. SOCIAL SECURITY NO. <u>N/A</u>		17. INFORMANT Address <u>FATHER - 4401 OVERLOOK AVE S.W. WASH. D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5 DUE TO PREMATUREITY</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>INTRAUTERINE ANOXIA</u> (c) <u>MATERNAL HEMORRHAGE</u>						INTERVAL BETWEEN ONSET AND DEATH <u>15 hrs</u> <u>24 hrs</u> <u>24 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>29 SEP</u> , 1958, to <u>29 SEP</u> , 1958, that I last saw the deceased alive on <u>29 SEP</u> , 1958, and that death occurred at <u>1845A</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>29 SEP 58 DATE SIGNED</u>				22. I certify that I attended the deceased from <u>29 SEP</u> , 1958, to <u>29 SEP</u> , 1958, that I last saw the deceased alive on <u>29 SEP</u> , 1958, and that death occurred at <u>1845A</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Vincent P. Ringrose, Jr.</u>				M.D. <u>USAF HOSPITAL, ANDREWS AFB, MD.</u>			
PHYSICIAN'S NAME (Type) <u>VINCENT P. RINGROSE JR.</u>				LOCATION (City, town, or county) (State) <u>USAF HOSPITAL, ANDREWS AFB, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/3/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>DATE OCT 2 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Kneub</u>	

MEDICAL CERTIFICATION

C
2

50

M

2050264XV4

CERTIFICATE OF DEATH

10782

1. NAME OF DECEASED JOHN J. SMITH		2. SEX Male		3. AGE 45		4. DATE OF DEATH 10/15/1918	
5. PLACE OF DEATH Home		6. CITY Baltimore		7. COUNTY Harford		8. STATE Md.	
9. OCCUPATION Engineer		10. CAUSE OF DEATH Heart Disease		11. MANNER OF DEATH Natural		12. SIGNATURE OF PHYSICIAN J. H. Smith	
13. SIGNATURE OF DECEASED John J. Smith		14. SIGNATURE OF WITNESSES John J. Smith		15. SIGNATURE OF DECEASED John J. Smith		16. SIGNATURE OF WITNESSES John J. Smith	
17. SIGNATURE OF DECEASED John J. Smith		18. SIGNATURE OF WITNESSES John J. Smith		19. SIGNATURE OF DECEASED John J. Smith		20. SIGNATURE OF WITNESSES John J. Smith	
21. SIGNATURE OF DECEASED John J. Smith		22. SIGNATURE OF WITNESSES John J. Smith		23. SIGNATURE OF DECEASED John J. Smith		24. SIGNATURE OF WITNESSES John J. Smith	
25. SIGNATURE OF DECEASED John J. Smith		26. SIGNATURE OF WITNESSES John J. Smith		27. SIGNATURE OF DECEASED John J. Smith		28. SIGNATURE OF WITNESSES John J. Smith	
29. SIGNATURE OF DECEASED John J. Smith		30. SIGNATURE OF WITNESSES John J. Smith		31. SIGNATURE OF DECEASED John J. Smith		32. SIGNATURE OF WITNESSES John J. Smith	
33. SIGNATURE OF DECEASED John J. Smith		34. SIGNATURE OF WITNESSES John J. Smith		35. SIGNATURE OF DECEASED John J. Smith		36. SIGNATURE OF WITNESSES John J. Smith	
37. SIGNATURE OF DECEASED John J. Smith		38. SIGNATURE OF WITNESSES John J. Smith		39. SIGNATURE OF DECEASED John J. Smith		40. SIGNATURE OF WITNESSES John J. Smith	
41. SIGNATURE OF DECEASED John J. Smith		42. SIGNATURE OF WITNESSES John J. Smith		43. SIGNATURE OF DECEASED John J. Smith		44. SIGNATURE OF WITNESSES John J. Smith	
45. SIGNATURE OF DECEASED John J. Smith		46. SIGNATURE OF WITNESSES John J. Smith		47. SIGNATURE OF DECEASED John J. Smith		48. SIGNATURE OF WITNESSES John J. Smith	
49. SIGNATURE OF DECEASED John J. Smith		50. SIGNATURE OF WITNESSES John J. Smith		51. SIGNATURE OF DECEASED John J. Smith		52. SIGNATURE OF WITNESSES John J. Smith	
53. SIGNATURE OF DECEASED John J. Smith		54. SIGNATURE OF WITNESSES John J. Smith		55. SIGNATURE OF DECEASED John J. Smith		56. SIGNATURE OF WITNESSES John J. Smith	
57. SIGNATURE OF DECEASED John J. Smith		58. SIGNATURE OF WITNESSES John J. Smith		59. SIGNATURE OF DECEASED John J. Smith		60. SIGNATURE OF WITNESSES John J. Smith	
61. SIGNATURE OF DECEASED John J. Smith		62. SIGNATURE OF WITNESSES John J. Smith		63. SIGNATURE OF DECEASED John J. Smith		64. SIGNATURE OF WITNESSES John J. Smith	
65. SIGNATURE OF DECEASED John J. Smith		66. SIGNATURE OF WITNESSES John J. Smith		67. SIGNATURE OF DECEASED John J. Smith		68. SIGNATURE OF WITNESSES John J. Smith	
69. SIGNATURE OF DECEASED John J. Smith		70. SIGNATURE OF WITNESSES John J. Smith		71. SIGNATURE OF DECEASED John J. Smith		72. SIGNATURE OF WITNESSES John J. Smith	
73. SIGNATURE OF DECEASED John J. Smith		74. SIGNATURE OF WITNESSES John J. Smith		75. SIGNATURE OF DECEASED John J. Smith		76. SIGNATURE OF WITNESSES John J. Smith	
77. SIGNATURE OF DECEASED John J. Smith		78. SIGNATURE OF WITNESSES John J. Smith		79. SIGNATURE OF DECEASED John J. Smith		80. SIGNATURE OF WITNESSES John J. Smith	
81. SIGNATURE OF DECEASED John J. Smith		82. SIGNATURE OF WITNESSES John J. Smith		83. SIGNATURE OF DECEASED John J. Smith		84. SIGNATURE OF WITNESSES John J. Smith	
85. SIGNATURE OF DECEASED John J. Smith		86. SIGNATURE OF WITNESSES John J. Smith		87. SIGNATURE OF DECEASED John J. Smith		88. SIGNATURE OF WITNESSES John J. Smith	
89. SIGNATURE OF DECEASED John J. Smith		90. SIGNATURE OF WITNESSES John J. Smith		91. SIGNATURE OF DECEASED John J. Smith		92. SIGNATURE OF WITNESSES John J. Smith	
93. SIGNATURE OF DECEASED John J. Smith		94. SIGNATURE OF WITNESSES John J. Smith		95. SIGNATURE OF DECEASED John J. Smith		96. SIGNATURE OF WITNESSES John J. Smith	
97. SIGNATURE OF DECEASED John J. Smith		98. SIGNATURE OF WITNESSES John J. Smith		99. SIGNATURE OF DECEASED John J. Smith		100. SIGNATURE OF WITNESSES John J. Smith	

RECEIVED OCTOBER 15 1918

11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10486

CERTIFICATE OF DEATH

10487

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 2 hours d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 3543 Madison Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Cora R. Hurlebaus		4. DATE OF DEATH Month September Day 1 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-26-00
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Statistician-Assistant to Auditor		10b. KIND OF BUSINESS OR INDUSTRY Mayflower Hotel	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William M. Furry		14. MOTHER'S MAIDEN NAME Elizabeth Hull	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 571-38-3116	
17. INFORMANT George W. Hurlebaus		Address 3543 Madison St. Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Subarachnoid Hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular Disease DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1 , 19 58 , to Sept 2 , 19 58 , that I last saw the deceased alive on Sept 2 , 19 58 , and that death occurred at 7:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3824-34th St Prince Georges DATE SIGNED Sept 2 58 ACTUAL SIGNATURE Benjamin L. Miller M.D. PHYSICIAN'S NAME (Type) Dr. R. Miller			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/4/58	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE S. H. - Horne CO - 2901-14 ST N.W		24a. REC'D BY REGISTRAR DATE SEP 4 '58	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

1416 BOLD

CERTIFICATE OF DEATH

1942

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 1, 1900		New York, N.Y.	
Cause of Death		Immediate Cause		Underlying Cause		Manner of Death		Place of Death	
Heart Disease		Myocardial Infarction		Coronary Atherosclerosis		Natural		Home	
Date of Death		Time of Death		Physician's Signature		Medical Examiner's Signature		Registrar's Signature	
Jan 15, 1942		10:30 AM		J. Smith, M.D.		A. Jones, M.D.		B. White, M.D.	
Hospital or Institution		Physician's Name		Medical Examiner's Name		Registrar's Name		Signature of Informant	
St. Mary's Hospital		Dr. J. Smith		Dr. A. Jones		Mr. B. White		Mrs. C. Black	
Address of Informant		Relationship to Deceased		Signature of Informant		Date of Statement		Place of Statement	
123 Main St.		Wife		Mrs. C. Black		Jan 16, 1942		Home	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10533

CERTIFICATE OF DEATH

Reg. Dist. No.

10488

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>District of Columbia</u> b. COUNTY <u>None</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wash D. C.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>USAF Hospital Andrews, Andrews AFB</u>				d. STREET ADDRESS <u>16 8th Street, S. E.</u>			
3. NAME OF DECEASED (Type or print) First <u>Jerry</u> Middle <u>Jackson</u> Last <u>Jackson</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>18</u> Year <u>19 58</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>16 Jul, 21</u>	9. AGE (In years last birthday) <u>37</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Airman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>USAF</u>		11. BIRTHPLACE (State or foreign country) <u>Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jake Jackson</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>42-45 417144131</u>		17. INFORMANT <u>OFFICIAL RECORDS US AIR FORCE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infarction of myocardium</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Occlusion</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>Undetermined</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u>	Month, <u> </u> Day, <u> </u> Year <u> 19 </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <u>DOA</u> , 19 <u> </u> , to <u> </u> , 19 <u> </u> , that I last saw the deceased alive on <u> </u> , 19 <u> </u> , and that death occurred at <u>0120AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>Stanley M. Sinkford</u>		M.D. <u>USAF HOSPITAL ANDREWS</u>		18 Sept 58			
PHYSICIAN'S NAME (Type) <u>STANLEY M SINKFORD CAPT USAF (MC)</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/19/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Montgomery, Ala.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Johnson F Jenkins Funeral Home</u>				ADDRESS <u>4804 G2 Ave NW</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 22 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10489

10487

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 7½ Hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bernard Middle Ignatius Last Johnson				4. DATE OF DEATH Month Sept. Day 23, Year 1958			
5. SEX Male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-17-08		9. AGE (In years last birthday) 49 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Roads		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Bernard Johnson				14. MOTHER'S MAIDEN NAME Mary Jane Trout			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 		16. SOCIAL SECURITY NO. 218-09-8989		17. INFORMANT Sterling Johnson; Bowie, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral compression 983X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Subdural and extra dural hemorrhage DUE TO (c) Laceration of brain and R. Middle Meningeal Artery							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hit on head by bottle thrown by another person.					
20c. TIME OF INJURY Month, Day, Year 12.08 PM 9-23-58 19		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Wagman Street		20f. (City or town) (County) (State) Oakerest Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John J. Maloney				DATE SIGNED			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Sept. 24, 1958			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-27-58		22c. NAME OF CEMETERY OR CREMATORY Church Cemetery		22d. LOCATION (City, town, or county) (State) Bowie Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines & Co. 3015 12th St. NE				24a. REC'D BY REGISTRAR DATE SEP 29 '58		24b. REGISTRAR'S SIGNATURE William S. Rhine	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health. or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10488

CERTIFICATE OF DEATH

Reg. Dist. No.

10490

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 25 RIVERDALE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRINCE GEORGES GENERAL HOSP.		d. STREET ADDRESS 5304 WASH. & BALTIMORE PKWY.	
3. NAME OF DECEASED (Type or print) LYDIA JONES		4. DATE OF DEATH SEPT. 25 Day 25 Year 1958	
5. SEX FEM.	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 28, 1900
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Jacob Wlaker		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Clyde E Jones		Address Riverdale, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 151x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic Carcinoma DUE TO (c) Carcinoma of Stomach INTERVAL BETWEEN ONSET AND DEATH 12 hours 2 yrs 2 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 1958 to Sept. 25, 1958 , that I last saw the deceased alive on Sept. 25 , 1958, and that death occurred at 9:10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3824-34 St Mt Rainier Md DATE SIGNED Sept 25 1958			
ACTUAL SIGNATURE Benjamin S. Miller		PHYSICIAN'S NAME (Type) BENJAMIN MILLER, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept 27, 1958	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Md.	
24a. REC'D BY REGISTRAR SEP 30 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Krawe	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10028

THE LAW

DATE

1913

25

25

1010

25

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10491
Reg. Dist. No.

10489

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cedar Heights	
c. LENGTH OF STAY in 1b D.O.A.		d. STREET ADDRESS 1106 64th Place	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Willie Lee Jones		4. DATE OF DEATH September 23 1958	
5. SEX Male		6. COLOR OF HAIR COLORED	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 9, 1958	
9. AGE (In years last birthday) 1 1/2		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew Witherspoon		14. MOTHER'S MAIDEN NAME Rebecca Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Rebecca Jones; same address as # 2.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial Hemorrhage, Choroid Plexus 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		September 23, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) 9-29-58		22b. DATE THEREOF Woodlawn	
22c. NAME OF CEMETERY OR CREMATORY Benning Rd		22d. LOCATION (City, town, or county) (State) S.E.	
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington		24a. REC'D BY REGISTRAR SEP 29 '58	
ADDRESS 467 N. 2nd St		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

2097306XV3

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 14
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
DEATH OF

Exhibits

Order

Johns Hopkins Hospital

September 13, 1933

Johns

Johns

September 13, 1933

Johns

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Johns Hopkins

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Johns Hopkins

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Johns Hopkins

Johns Hopkins

September 13, 1933

September 13, 1933

September 13, 1933

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10490

CERTIFICATE OF DEATH

Reg. Dist. No.

10492

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 7 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sue Middle sanna Last Kelly		4. DATE OF DEATH Month September Day 28 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/23/85
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Robert Swan		14. MOTHER'S MAIDEN NAME Mary Williams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Dorothy Mc Ardel		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 467.1 Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Venous Aneurysm, Liver DUE TO (c) Multiple Hereditary Telangiectasia			INTERVAL BETWEEN ONSET AND DEATH 2 weeks 2 mos. 72 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 19 54 , to Sept 28 , 19 58 , that I last saw the deceased alive on Sept. 28 , 19 58 , and that death occurred at 12:15 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Norman Donat Comen M.D.		ADDRESS (Street, city or town, state) 3503 Pennys. DATE SIGNED 9/28/58	
PHYSICIAN'S NAME (Type) NORMAN DONAT COMEN		MT RAINIER MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/30/58	22c. NAME OF CEMETERY OR CREMATORY White Marsh Cemetery	22d. LOCATION (City, town, or county) (State) White Marsh, Maryland.
23. FUNERAL DIRECTOR'S SIGNATURE F Gasch's Sons		ADDRESS Hyattsville Md.	
24a. REC'D BY REGISTRAR DATE SEP 30 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hays	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1910

Reg. No. 100

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY		STATE	
JAMES H. HARRIS		Male		45		1865		Maryland		Baltimore		Baltimore		Maryland	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		HOUR OF DEATH		PLACE OF DEATH		CITY	
Carpenter		Heart Disease		Natural		Several Weeks		1910		10:00 AM		Baltimore		Baltimore	
FAMILY HISTORY		PREVIOUS ILLNESS		EDUCATION		RELIGION		MARRIAGE		CHILDREN		Siblings		Other	
None		None		High School		Roman Catholic		Married		2 Children		1 Brother		1 Sister	
Burial		Funeral		Interment		Cemetery		Date		Time		Place		City	
St. Mary's		St. Mary's		St. Mary's		St. Mary's		1910		10:00 AM		St. Mary's		Baltimore	

1

10491

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10493
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kirby Hills</u>			
c. LENGTH OF STAY IN 1b <u>17 hours</u>				d. STREET ADDRESS <u>4823 Barrymore Drive</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Keland Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ruby</u> Middle <u>AGNES</u> Last <u>Kleaver</u>				4. DATE OF DEATH Month <u>9</u> Day <u>9</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-2-1914</u>	
9. AGE (In years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William F. Springfield</u>				14. MOTHER'S MAIDEN NAME <u>Marjorie Acton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Husband - 4823 Barrymore Dr. Kirby Hills</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>194x POST OPERATIVE SHOCK</u> DUE TO (b) <u>Severe Anemia</u> DUE TO (c) <u>Metastatic Hypoid Carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u> <u>2 months</u> <u>6 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>9/8</u> , 19 <u>58</u> , to <u>9/9</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9/9</u> , 19 <u>58</u> , and that death occurred at <u>5:55 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Bowland Wilkinson</u> M.D.				ADDRESS (Street, city or town, state) <u>4404 Queensbury Road</u>			
PHYSICIAN'S NAME (Type) <u>ROCLAND F WILKINSON</u>				DATE SIGNED <u>Riverdale Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>SEP. 12, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. CHAMBERS CO.</u>				ADDRESS <u>517 11th St. S.E. Wash., D.C.</u>		24a. REC'D BY REGISTRAR <u>SEP 15 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10458

CERTIFICATE OF DEATH

10494

Reg. Dist. No.

1. PLACE OF DEATH ¹ a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u>	
c. LENGTH OF STAY IN 1b <u>1 yr.</u>		d. STREET ADDRESS <u>4022-35th St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4022-35th St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Kozlowski</u> Last <u>Kozlowski</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>11</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 17, 1904</u>
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR: Months <u>54</u> Days <u>54</u> Hours <u>54</u> Min. <u>54</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Counter man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>	
11. BIRTHPLACE (State or foreign country) <u>Middle Town, New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Stanley Kozlowski</u>		14. MOTHER'S MAIDEN NAME <u>Veronica</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-09-9643</u>	
17. INFORMANT <u>Georgia Kozlowski</u>		Address <u>4022-35 St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic Heart Disease</u> DUE TO (c) <u>1 year</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u> <u>2 mins.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 1</u> , 19 <u>58</u> , to <u>Sept. 11</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept. 10</u> , 19 <u>58</u> , and that death occurred at <u>4:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles C. Hageage</u>		ADDRESS (Street, city or town, state) <u>3308 Perry St. Mt. Rainier, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Charles C. Hageage M.D.</u>		DATE SIGNED <u>9/11/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/13/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood</u>	22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Gasch's SONS</u>		ADDRESS <u>4739 Balto. Ave. Hyattsville, Md.</u>	
24a. REC'D BY REGISTRAR <u>SEP 15 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1-1-1918

WOMAN

Name of Deceased		Age		Sex	
Mabel Louise		35		Female	
Date of Death		Place of Death		Cause of Death	
Jan 1, 1918		Boston, Mass.		Diphtheria	
Time of Death		Occupation		Manner of Death	
10:30 A.M.		Housewife		Natural	
Signature of Physician		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]	
Address of Deceased		Address of Informant		Address of Coroner	
123 Main St.		456 Elm St.		789 Oak St.	
City		City		City	
Boston		Boston		Boston	
State		State		State	
Mass.		Mass.		Mass.	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10492

CERTIFICATE OF DEATH

10495

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 9 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly d. STREET ADDRESS 6015 Forest Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John B. Kuhn		4. DATE OF DEATH Month September Day 29 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/2/93
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Foreman Stone setter		10b. KIND OF BUSINESS OR INDUSTRY Task stone	
11. BIRTHPLACE (State or foreign country) Hanover, Penna.		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Francis Xavier Kuhn, Sr.		14. MOTHER'S MAIDEN NAME Ann Stock	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. 577-05-2970	
17. INFORMANT Velna Kuhn		Address address same Wife	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Melanotic sarcoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Renal cell sarcoma DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 180x			INTERVAL BETWEEN ONSET AND DEATH 3 mo 6 mo
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from September 19 1958 , to September 29 1958 , that I last saw the deceased alive on September 29 1958 , and that death occurred at 6:45 A. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3404 Cheverly Ave DATE SIGNED Cheverly, Md.			
ACTUAL SIGNATURE John Kehoe		PHYSICIAN'S NAME (Type) John Kehoe M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/3/1958	22c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery	22d. LOCATION (City, town, or county) (State) McSherrystown, Penna.
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		24a. REC'D BY REGISTRAR DATE OCT 2 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kross

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10-03

1-1-19

Name of Deceased		Date of Birth		Sex		Race		Marital Status		Occupation	
John Doe		1/1/19		Male		White		Married		Teacher	
Place of Birth		Date of Death		Time of Death		Cause of Death		Manner of Death		Place of Death	
New York City		10/1/19		10:00 AM		Heart Disease		Natural		Home	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Funeral Home		Signature of Family	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Name of Funeral Home		Address of Funeral Home		City		State		Zip		Phone	
Doe Funeral Home		123 Main St		Baltimore		MD		21201		(410) 555-1234	

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 6, Film G234, 10/3/58 for
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

Reg. Disf. No.

10496

10534

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY -			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)				c. LENGTH OF STAY IN 1b 9 months and 20 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				d. STREET ADDRESS 606 H. St., N. W.			
3. NAME OF DECEASED (Type or print) First Shi Middle Yick Last Lee				4. DATE OF DEATH Month 9 Day 26 Year 19 58			
5. SEX Male		6. COLOR OR RACE Chinese White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/23/1893	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months - Days - Hours - Min. -		IF UNDER 24 HRS. Months - Days - Hours - Min. -			
10a. MAJOR OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laundry Worker				10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) China	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Munon Lee				14. MOTHER'S MAIDEN NAME Won Shee			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		(If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Decedent	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Alveolar cell carcinoma of right lung with metastasis to both lungs. 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH 11 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 12/6, 1957 , to 9/26, 1958 , that I last saw the deceased alive on 9/25, 1958 , and that death occurred at 6:45 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Moe Weiss M.D.				ADDRESS (Street, city or town, state) Glenn Dale Hospital DATE SIGNED 9/26/58			
PHYSICIAN'S NAME (Type) Moe Weiss, M. D.				Glenn Dale, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 9/28		22c. NAME OF CEMETERY OR CREMATORY Lorraine Park		22d. LOCATION (City, town, or county) (State) Croftdown-Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Kraus ADDRESS Baltimore City - Md.				24a. REC'D BY REGISTRAR SEP 30 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

IRVING STATE DEPARTMENT OF HEALTH-BALTIMORE 78

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10493

CERTIFICATE OF DEATH

10497

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Prince Georges General</u>				e. STREET ADDRESS <u>3806 37th Ave. Cottage City</u>			
3. NAME OF DECEASED (Type or print) <u>Erlamond</u> First Middle Last				4. DATE OF DEATH <u>Sept</u> Month <u>30</u> Day <u>1958</u> Year			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/8/1897</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <u>60</u> yrs.		11. BIRTHPLACE (State or foreign country) <u>Tamaqua, Pennsylvania</u>	
13. FATHER'S NAME <u>Frank Wagner</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Edward W. Lempke-3806-38th Ave.</u> Address <u>Cottage City, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular disease 10 yrs</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>9</u> p. m. 19 <u>58</u>				20d. INJURY OCCURRED White at work <input type="checkbox"/> Nat white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>45</u> , to <u>Sept 30</u> , 19 <u>58</u> that I last saw the deceased alive on <u>9/30</u> , 19 <u>58</u> , and that death occurred at <u>8:45</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3712-38th Pl SE Hyattsville, Md.</u> DATE SIGNED <u>9/30/58</u>							
ACTUAL SIGNATURE <u>George J. Hageage</u> M.D.				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
PHYSICIAN'S NAME (Type) <u>George J. Hageage</u>				22b. DATE THEREOF <u>Oct. 6, 1958</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co-2901 14th St NW DC</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem. Arlington, Virginia</u>			
24a. REC'D BY REGISTRAR <u>OCT 2 '58</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hageage</u>			

10494

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>33 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lloyd</u>		4. DATE OF DEATH Month <u>September</u> Day <u>27</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/16/92</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman Jeweler</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Luther D Le Roy</u>		14. MOTHER'S MAIDEN NAME <u>Ollie Forline</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Helen M Le Roy</u>		Address <u>Kent Village, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> <u>420.1</u> DUE TO <u>Coronary Atherosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>years</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>MASSIVE GASTRO-COLIC FISTULA</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 25</u> , 19 <u>58</u> , to <u>September 27</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>September 27</u> , 19 <u>58</u> , and that death occurred at <u>1:40 PM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Fredrick E. Musser</u> M.D.		ADDRESS (Street, city or town, state) <u>7409 Varnum St</u> DATE SIGNED <u>9/27/58</u>	
PHYSICIAN'S NAME (Type) <u>Fredrick E. Musser M.D.</u>		<u>Landover Hills, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>Sept 27, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Crematory</u>	22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 30 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
1932
CERTIFICATE OF DEATH

Page 1 of 1

1. Name of deceased <u>Robert J. Fisher</u>		2. Sex <u>Male</u>		3. Age <u>35</u>	
4. Date of death <u>April 15, 1932</u>		5. Time of death <u>10:30 AM</u>		6. Place of death <u>Home</u>	
7. Cause of death <u>Myocardial Infarction</u>		8. Nature of disease <u>Coronary Artery Disease</u>		9. Duration of illness <u>2 weeks</u>	
10. Name of physician <u>Dr. J. H. Smith</u>		11. Name of hospital <u>None</u>		12. Name of funeral home <u>Johns & Sons</u>	
13. Name of informant <u>Robert J. Fisher</u>		14. Name of witness <u>Johns & Sons</u>		15. Name of registrar <u>Johns & Sons</u>	
16. Name of undertaker <u>Johns & Sons</u>		17. Name of cemetery <u>None</u>		18. Name of church <u>None</u>	
19. Name of place of burial <u>None</u>		20. Name of place of interment <u>None</u>		21. Name of place of cremation <u>None</u>	
22. Name of place of entombment <u>None</u>		23. Name of place of inhumation <u>None</u>		24. Name of place of disposition <u>None</u>	
25. Name of place of disposal <u>None</u>		26. Name of place of disposal <u>None</u>		27. Name of place of disposal <u>None</u>	
28. Name of place of disposal <u>None</u>		29. Name of place of disposal <u>None</u>		30. Name of place of disposal <u>None</u>	
31. Name of place of disposal <u>None</u>		32. Name of place of disposal <u>None</u>		33. Name of place of disposal <u>None</u>	
34. Name of place of disposal <u>None</u>		35. Name of place of disposal <u>None</u>		36. Name of place of disposal <u>None</u>	
37. Name of place of disposal <u>None</u>		38. Name of place of disposal <u>None</u>		39. Name of place of disposal <u>None</u>	
40. Name of place of disposal <u>None</u>		41. Name of place of disposal <u>None</u>		42. Name of place of disposal <u>None</u>	
43. Name of place of disposal <u>None</u>		44. Name of place of disposal <u>None</u>		45. Name of place of disposal <u>None</u>	
46. Name of place of disposal <u>None</u>		47. Name of place of disposal <u>None</u>		48. Name of place of disposal <u>None</u>	
49. Name of place of disposal <u>None</u>		50. Name of place of disposal <u>None</u>		51. Name of place of disposal <u>None</u>	
52. Name of place of disposal <u>None</u>		53. Name of place of disposal <u>None</u>		54. Name of place of disposal <u>None</u>	
55. Name of place of disposal <u>None</u>		56. Name of place of disposal <u>None</u>		57. Name of place of disposal <u>None</u>	
58. Name of place of disposal <u>None</u>		59. Name of place of disposal <u>None</u>		60. Name of place of disposal <u>None</u>	
61. Name of place of disposal <u>None</u>		62. Name of place of disposal <u>None</u>		63. Name of place of disposal <u>None</u>	
64. Name of place of disposal <u>None</u>		65. Name of place of disposal <u>None</u>		66. Name of place of disposal <u>None</u>	
67. Name of place of disposal <u>None</u>		68. Name of place of disposal <u>None</u>		69. Name of place of disposal <u>None</u>	
70. Name of place of disposal <u>None</u>		71. Name of place of disposal <u>None</u>		72. Name of place of disposal <u>None</u>	
73. Name of place of disposal <u>None</u>		74. Name of place of disposal <u>None</u>		75. Name of place of disposal <u>None</u>	
76. Name of place of disposal <u>None</u>		77. Name of place of disposal <u>None</u>		78. Name of place of disposal <u>None</u>	
79. Name of place of disposal <u>None</u>		80. Name of place of disposal <u>None</u>		81. Name of place of disposal <u>None</u>	
82. Name of place of disposal <u>None</u>		83. Name of place of disposal <u>None</u>		84. Name of place of disposal <u>None</u>	
85. Name of place of disposal <u>None</u>		86. Name of place of disposal <u>None</u>		87. Name of place of disposal <u>None</u>	
88. Name of place of disposal <u>None</u>		89. Name of place of disposal <u>None</u>		90. Name of place of disposal <u>None</u>	
91. Name of place of disposal <u>None</u>		92. Name of place of disposal <u>None</u>		93. Name of place of disposal <u>None</u>	
94. Name of place of disposal <u>None</u>		95. Name of place of disposal <u>None</u>		96. Name of place of disposal <u>None</u>	
97. Name of place of disposal <u>None</u>		98. Name of place of disposal <u>None</u>		99. Name of place of disposal <u>None</u>	
100. Name of place of disposal <u>None</u>		101. Name of place of disposal <u>None</u>		102. Name of place of disposal <u>None</u>	

10453

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY New York	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hottsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New York City	
c. LENGTH OF STAY IN 1b 1 year		16X-1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8910 Riggs Road		d. STREET ADDRESS 225 W. 14th St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JUSTINE Middle NEVESQUE Last NEVESQUE		4. DATE OF DEATH Month Sept. Day 29 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 13, 1874
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Religious Nun		10b. KIND OF BUSINESS OR INDUSTRY Religious	
11. BIRTHPLACE (State or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY? Canada ✓	
13. FATHER'S NAME Joseph Levesque		14. MOTHER'S MAIDEN NAME Justine Bonneenfant	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Mother Mary Aquinas		Address 8910 Riggs Road, Hyattsville Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Arteriosclerosis Generalized DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			INTERVAL BETWEEN ONSET AND DEATH 2 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Sept. 1957 , to Sept. 29, 1958 , that I last saw the deceased alive on Sept. 29, 1958 , and that death occurred at 2:30 P M, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE James L. Laubach, MD M.D.		1806 Fox St.	
PHYSICIAN'S NAME (Type) JAMES L. LAUBACH		Hyattsville Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-2-58	22c. NAME OF CEMETERY OR CREMATORY Benjamin Cemetery	22d. LOCATION (City, town, or county) (State) Hyattsville Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins		ADDRESS 3821-14th St. NW, Wash. D.C.	
24. REC'D BY REGISTRAR OCT 1 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10-23

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH 10-23-1928		5. PLACE OF BIRTH MOBILE, ALABAMA		6. OCCUPATION None	
7. STREET ADDRESS 1000 ...		8. CITY BALTIMORE		9. STATE MD		10. ZIP CODE 21201		11. COUNTY BALTIMORE		12. MARITAL STATUS Single	
13. DATE OF DEATH 10-23-1968		14. TIME OF DEATH 10:00 AM		15. PLACE OF DEATH Prison		16. CAUSE OF DEATH Heart Disease		17. MANNER OF DEATH Natural		18. SIGNATURE OF DECEASED (None)	
19. SIGNATURE OF PHYSICIAN J. Edgar Hoover		20. SIGNATURE OF WITNESS J. Edgar Hoover		21. SIGNATURE OF CORONER J. Edgar Hoover		22. SIGNATURE OF MINISTER J. Edgar Hoover		23. SIGNATURE OF ... J. Edgar Hoover		24. SIGNATURE OF ... J. Edgar Hoover	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT OF THE BALTIMORE CITY AND COUNTY, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT OF THE BALTIMORE CITY AND COUNTY, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT OF THE BALTIMORE CITY AND COUNTY, BALTIMORE, MARYLAND.

10535

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Laurel</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Rural Laurel</u>			
c. LENGTH OF STAY IN 1b <u>30 yr</u>				d. STREET ADDRESS <u>Laurel-Bowie Road</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Laurel-Bowie Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Brackinridge Long</u>				4. DATE OF DEATH <u>September 26 1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 16, 1881</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>St. Louis Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Strudwick Long</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Brackinridge</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Arnold Wilcox, 3804 Bradley Lane, Chevy Chase Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral haemorrhage</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio sclerosis</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7-6 months</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May</u> , 19 <u>50</u> , to <u>Sept 26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 26</u> , 19 <u>58</u> , and that death occurred at <u>2 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert S. McCleney</u> M.D.				ADDRESS (Street, city or town, state) <u>402 Main St.</u>			
DATE SIGNED							
PHYSICIAN'S NAME (Type) <u>Robert S. McCleney M.D. Laurel Md.</u>							
22a. BURIAL (CREMATION) REMOVAL (Specify)		22b. DATE THEREOF <u>9/29/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CECILE HILL CREMATORY</u>		22d. LOCATION (City, town, or county) (State) <u>SUITHLAND, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Strubbe</u> ADDRESS <u>1730 Penna Ave</u>				24a. REC'D BY REGISTRAR <u>SEP 29 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10454

CERTIFICATE OF DEATH

10501

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WASHINGTON, D.C. b. COUNTY WASHINGTON, D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, D.C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CARROLL MANOR		d. STREET ADDRESS 2100 Massachusetts Ave., N.W.	
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES H. MCCARTHY		4. DATE OF DEATH Month SEPT Day 13 Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 14, 1878
9. AGE (In years lost birthday) 79 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ATTORNEY-AT-LAW		10b. KIND OF BUSINESS OR INDUSTRY GOV'T.	
11. BIRTHPLACE (State or foreign country) PAWTUCKET, RHODE ISLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DANIEL MCCARTHY		14. MOTHER'S MAIDEN NAME MARY SULLIVAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Sister M. Jean Therese Carroll Manor		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 hr.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 19 57 , to 9/13 , 19 58 , that I last saw the deceased alive on 9/5 , 19 58 , and that death occurred at 9:25 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Frank M Trozzo		ADDRESS (Street, city or town, state) 1840 Michigan Ave. N.E. D.C.	
PHYSICIAN'S NAME (Type) FRANK M. TROZZO		DATE SIGNED 9/13/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/16/1958	
22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		22d. LOCATION (City, town, or county) (State) Silver Spring, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Sewler		ADDRESS Wash. D.C.	
24a. REC'D BY REGISTRAR SEP 16 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10502

Reg. Dist. No.

10536

1. PLACE OF DEATH COUNTY <u>Prince George</u> <u>Montgomery</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Laurel (rural)</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Band Mill Road</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Pr. George</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Laurel</u> STREET ADDRESS (If rural give location) <u>Band Mill Road</u>			
3. NAME OF DECEASED (Type or Print) <u>Harry W</u> (First) <u>McClelland</u> (Middle) (Last)				4. DATE OF DEATH <u>Sept. 5,</u> 19 <u>58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 20, 1898</u>	9. AGE last birthday <u>59</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodian</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public School</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Harry T. S. McClelland</u>				14. MOTHER'S MAIDEN NAME <u>Elsie May Burns</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>XXXXXXXXXXXX</u>		17. INFORMANT & ADDRESS <u>Mrs. Ida Burton McClelland, Laurel, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
331X IMMEDIATE CAUSE (A) <u>Cerebral vascular accident</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Atherosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Hypertension</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <input type="checkbox"/>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6-15</u> , 19 <u>58</u> , to <u>8-26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8/26</u> , 19 <u>58</u> , and that death occurred at <u>8</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Arthur S. Weaver</u>			ADDRESS (Street, city, town, state) <u>M.D. 320 Montgomery, Laurel, Md.</u>		DATE SIGNED <u>9/6/58</u>		
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Sept. 8, 1958</u>		NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		LOCATION (City, town, or county) (State) <u>Burtonsville, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>SEP 9 '58</u>		REGISTRAR'S SIGNATURE <u>Arthur S. Weaver</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William H. Weaver</u> ADDRESS			

1. *Introduction*

2. *Method*

3. *Results*

4. *Discussion*

5. *Conclusion*

6. *Acknowledgements*

7. *References*

8. *Appendix*

9. *Notes*

10. *References*

11. *Appendix*

12. *Notes*

13. *References*

14. *Appendix*

15. *Notes*

16. *References*

17. *Appendix*

18. *Notes*

19. *References*

20. *Appendix*

21. *Notes*

22. *References*

23. *Appendix*

24. *Notes*

25. *References*

26. *Appendix*

27. *Notes*

28. *References*

29. *Appendix*

30. *Notes*

31. *References*

32. *Appendix*

33. *Notes*

34. *References*

35. *Appendix*

36. *Notes*

37. *References*

38. *Appendix*

39. *Notes*

40. *References*

41. *Appendix*

42. *Notes*

43. *References*

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49. *References*

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51. *Notes*

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54. *Notes*

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57. *Notes*

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60. *Notes*

61. *References*

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74. *Appendix*

75. *Notes*

76. *References*

77. *Appendix*

78. *Notes*

79. *References*

80. *Appendix*

81. *Notes*

82. *References*

83. *Appendix*

84. *Notes*

85. *References*

86. *Appendix*

87. *Notes*

88. *References*

89. *Appendix*

90. *Notes*

91. *References*

92. *Appendix*

93. *Notes*

94. *References*

95. *Appendix*

96. *Notes*

97. *References*

98. *Appendix*

99. *Notes*

100. *References*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10455

CERTIFICATE OF DEATH

Reg. Dist. No.

10503

1. PLACE OF DEATH o. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE		c. LENGTH OF STAY IN 1b 4 months X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CARROLL MANOR		d. STREET ADDRESS 4754 LESLIE AVE.	
3. NAME OF DECEASED (Type or print) First SAMUEL Middle S. Last MILLER		4. DATE OF DEATH Month 9 Day 5 Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/15/84
9. AGE (In years lost birthday) yrs. 74		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY BETHLEHEM STEEL CO. COATESVILLE, PA.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HALLOWELL W. MILLER		14. MOTHER'S MAIDEN NAME CLARA LILLEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 577-52-4083	
17. INFORMANT Sister M. Jean Thrun Address 4922 La Belle Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cremia DUE TO 177X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diffuse carcinomatous obstruction DUE TO Carcinoma of prostate (c) Carcinoma of prostate		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 5, 1958 , to Sept 5, 1958 , that I last saw the deceased alive on Sept 5, 1958 , and that death occurred at 8:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Richard P. DeLaney M.D. 9404 Coleville Rd, Silver Spring		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) RICHARD P. DELANEY			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Sept 8-58	Cedar Hill	Suitland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros. 1661-9d Hope Rd SE		24a. REC'D BY REGISTRAR SEP 8 '58	
ADDRESS 2222 20 DC		24b. REGISTRAR'S SIGNATURE Christina S. Harris	

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10504

CERTIFICATE OF DEATH

Reg. Dist. No.

10495

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Pr. Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. LENGTH OF STAY IN 1b <u>18 days.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Beland Memorial Hosp.</u>				d. STREET ADDRESS <u>14907-43rd Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Betty</u> Middle <u>Naomi</u> Last <u>Miner</u>				4. DATE OF DEATH Month <u>9</u> Day <u>20</u> Year <u>1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-31-80</u>		9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H. W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Henry Hull</u>				14. MOTHER'S MAIDEN NAME <u>Maria Dennis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>hosp. records.</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>331X</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Several anterior scleroses</u> DUE TO <u> </u> (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>18 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. <u> </u> m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 20</u> , 19 <u>58</u> , to <u>Sept 20</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 20</u> , 19 <u>58</u> , and that death occurred at <u>10:20</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L. W. Malin</u> M.D.				ADDRESS (Street, city or town, state) <u>Riverdale, Md.</u> DATE SIGNED <u>9-20-58</u>			
PHYSICIAN'S NAME (Type) <u>L. W. Malin M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 23, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u>				24a. REC'D BY REGISTRAR <u>SEP 24 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth		6. Date of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Date of registration	
JAMES EARL RAY		Male		35		Jan 5, 1928		Memphis, Tenn.		Jan 6, 1968		Memphis, Tenn.		Shot		Homicide		J. Edgar Hoover		J. Edgar Hoover		Jan 6, 1968	
13. Name of informant		14. Relationship		15. Address		16. City		17. State		18. Zip		19. Telephone		20. Signature of informant		21. Signature of registrar		22. Date of registration		23. Signature of physician		24. Signature of registrar	
J. Edgar Hoover		Wife		1000 ...		Memphis		Tenn.		38102		...		J. Edgar Hoover		J. Edgar Hoover		Jan 6, 1968		J. Edgar Hoover		J. Edgar Hoover	

1. Name of deceased
2. Sex
3. Age
4. Date of birth
5. Place of birth
6. Date of death
7. Place of death
8. Cause of death
9. Manner of death
10. Signature of physician
11. Signature of registrar
12. Date of registration
13. Name of informant
14. Relationship
15. Address
16. City
17. State
18. Zip
19. Telephone
20. Signature of informant
21. Signature of registrar
22. Date of registration
23. Signature of physician
24. Signature of registrar

10496

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>			c. LENGTH OF STAY IN 1b <u>28 1/2</u> hours			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landover</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General</u>				d. STREET ADDRESS <u>7562 Hawthorne St</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Baby Boy Mullenhour</u>		First Middle Last		4. DATE OF DEATH <u>Sept 9 19 58</u>		Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 8, 1958</u>		9. AGE (In years last birthday) yrs. <u>1</u> <u>4</u> <u>30</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Cheverly Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Donald E. Mullenhour</u>				14. MOTHER'S MAIDEN NAME <u>Ruth M. Mullenhour Ferreira</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>773.5</u> DUE TO <u>Pulmonary hyaline membrane disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pressure at birth</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 8, 1958</u> to <u>Sept. 9, 1958</u> , that I last saw the deceased alive on <u>Sept. 9, 1958</u> , and that death occurred at <u>5:00 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3404 Cheverly Ave. Cheverly, Md.</u> DATE SIGNED							
ACTUAL SIGNATURE <u>John Keohoe</u> M.D.				PHYSICIAN'S NAME (Type) <u>Dr. Keohoe, John</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>9/13/58</u>		<u>Notre Dame</u>		<u>Fall River, Mass.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home Inc.</u>				ADDRESS <u>Int. Raining</u>		24a. REC'D BY REGISTRAR <u>SEP 15 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MD-201-11

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Date of death		6. Place of death	
John Doe		Male		White		1/1/1900		1/15/1980		Baltimore, Md.	
7. Cause of death		8. Manner of death		9. Occupation		10. Education		11. Marital status		12. Social status	
Heart disease		Natural		Teacher		High School		Married		Middle class	
13. Signature of physician		14. Signature of registrar		15. Signature of informant		16. Signature of witness		17. Signature of funeral director		18. Signature of undertaker	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
19. Date of filing		20. Filing office		21. Filing number		22. Filing date		23. Filing time		24. Filing place	
1/15/1980		Baltimore, Md.		100-123456		1/15/1980		10:00 AM		Baltimore, Md.	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10506

10497

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo-</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenbelt - 23</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges Gen. Hosp</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Sharon Ann Myrick</u>			4. DATE OF DEATH <u>Sept. 25</u> 19 <u>58</u>		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-4-58</u>	9. AGE (In years last birthday) <u>21</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>James Madison Myrick, Jr.</u>			14. MOTHER'S MAIDEN NAME <u>Mary Bennett</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>JAMES M. MYRICK, JR. - 1423-HILLSIDE RD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tetanus</u> <u>763.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Pneumonitis</u> (a), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>John J. Maloney</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>JOHN T. MALONEY, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>Sept 25, 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/29/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem.</u>	22d. LOCATION (City, town, or county)	(State) <u>VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co - Riverdale, Md</u>		ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE	
			DATE <u>SEP 29 '58</u>	<u>Arthur E. Knaus</u>	

2077202 Xv6

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Handwritten notes and signatures, including "The Medical Examiner" and "John T. Murphy".

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
John T. Murphy		45		Male		White		1912		Boston, Mass.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL EXAMINER		SIGNATURE	
123 Main St.		Teacher		Heart Disease		Natural		John T. Murphy		[Signature]	
DATE OF EXAMINATION		TIME OF EXAMINATION		PLACE OF EXAMINATION		SIGNATURE OF EXAMINER		DATE OF EXAMINATION		TIME OF EXAMINATION	
1912		10:00 AM		123 Main St.		John T. Murphy		1912		10:00 AM	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10507

10537

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY Bronx		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) T. B.		c. LENGTH OF STAY IN Transient		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New York 69x-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route # 381			d. STREET ADDRESS 136 W 170th Street		
3. NAME OF DECEASED (Type or print) Matthew John Norton			4. DATE OF DEATH Month September Day 18 Year 19 58		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 20, 1896		9. AGE (In years last birthday) 62 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Policeman		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY U. S. A.			13. FATHER'S NAME Martin Norton		
14. MOTHER'S MAIDEN NAME Gertrude Creighton			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW 1		
16. SOCIAL SECURITY NO.			17. INFORMANT Kathekene Norton, same as # 2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442x Acute congestive heart failure DUE TO (b) Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED September 18, 1958	
EXAMINER'S NAME (Type) James I. Boyd		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 22, 1958		22c. NAME OF CEMETERY OR CREMATOR Gate of Heaven	
22d. LOCATION (City, town, or county) New York		22e. (State) New York			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Md.		24a. REC'D BY REGISTRAR SEP 23 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MISSISSIPPI STATE DEPARTMENT OF HEALTH - BIRMINGHAM
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MISSISSIPPI
DEPARTMENT OF HEALTH

MISSISSIPPI STATE DEPARTMENT OF HEALTH - BIRMINGHAM
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Medical Examiner	
10. Signature of Coroner		11. Signature of Juror		12. Signature of Witness	
13. Signature of Physician		14. Signature of Nurse		15. Signature of Other	
16. Signature of Family		17. Signature of Friend		18. Signature of Other	
19. Signature of Other		20. Signature of Other		21. Signature of Other	
22. Signature of Other		23. Signature of Other		24. Signature of Other	
25. Signature of Other		26. Signature of Other		27. Signature of Other	
28. Signature of Other		29. Signature of Other		30. Signature of Other	
31. Signature of Other		32. Signature of Other		33. Signature of Other	
34. Signature of Other		35. Signature of Other		36. Signature of Other	
37. Signature of Other		38. Signature of Other		39. Signature of Other	
40. Signature of Other		41. Signature of Other		42. Signature of Other	
43. Signature of Other		44. Signature of Other		45. Signature of Other	
46. Signature of Other		47. Signature of Other		48. Signature of Other	
49. Signature of Other		50. Signature of Other		51. Signature of Other	
52. Signature of Other		53. Signature of Other		54. Signature of Other	
55. Signature of Other		56. Signature of Other		57. Signature of Other	
58. Signature of Other		59. Signature of Other		60. Signature of Other	
61. Signature of Other		62. Signature of Other		63. Signature of Other	
64. Signature of Other		65. Signature of Other		66. Signature of Other	
67. Signature of Other		68. Signature of Other		69. Signature of Other	
70. Signature of Other		71. Signature of Other		72. Signature of Other	
73. Signature of Other		74. Signature of Other		75. Signature of Other	
76. Signature of Other		77. Signature of Other		78. Signature of Other	
79. Signature of Other		80. Signature of Other		81. Signature of Other	
82. Signature of Other		83. Signature of Other		84. Signature of Other	
85. Signature of Other		86. Signature of Other		87. Signature of Other	
88. Signature of Other		89. Signature of Other		90. Signature of Other	
91. Signature of Other		92. Signature of Other		93. Signature of Other	
94. Signature of Other		95. Signature of Other		96. Signature of Other	
97. Signature of Other		98. Signature of Other		99. Signature of Other	
100. Signature of Other		101. Signature of Other		102. Signature of Other	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										10508
Item 18 Film 234 9/24/58 ams										10538
CERTIFICATE OF DEATH										Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY Prince George County MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Colo b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TB Junction					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Denver 44X-3
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF Hospital Andrews					d. STREET ADDRESS 3459 So Fairfax St					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Gary D Patchen					4. DATE OF DEATH Month Day Year Sept 14 19 58					
5. SEX Male		6. COLOR OR RACE Cau		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 15 Oct 1936		9. AGE (In years last birthday) 22 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pilot				10b. KIND OF BUSINESS OR INDUSTRY US Navy		11. BIRTHPLACE (State or foreign country) Okla.			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Clarence Adrain Patchen					14. MOTHER'S MAIDEN NAME Sylvia Bell Thomas					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 443-32-4467		17. INFORMANT Official Records				Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]										INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 816X										
DUE TO Injuries, multiple extreme severe, chest and head										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
DUE TO										
DUE TO										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Headon collision rt 5, 1 mile north TB Junction PG Co., Md.						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 0200 p. m. 14 Sep 19 58				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway # 5		20f. (City or town) TB Junction (County) P.G. County (State)		
21. I certify that I attended the deceased from 14 Sep 19 58 to 14 Sep 19 58, that I last saw the deceased alive on 14 Sep 19 58, and that death occurred at 2:00 P.M. from the causes and on the date stated above.										
ACTUAL SIGNATURE Marvin E Haskin					ADDRESS (Street, city or town, state)					DATE SIGNED
PHYSICIAN'S NAME (Type) MARVIN E HASKIN CAPT USAF(MC)					USAF HOSPITAL ANDREWS					
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal			22b. DATE THEREOF 9/15/58		22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City, town, or county) (State) Denver, Colorado		
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.					24a. REC'D BY REGISTRAR DATE SEP 18 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

B2/C2/A6

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE COUNTY</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>WASHINGTON, D.C.</u> b. COUNTY <u>WASHINGTON, D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>				c. LENGTH OF STAY IN 1b <u>10 mos.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CARROLL MANOR</u>				e. STREET ADDRESS <u>5610 COLORADO AVE., N.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>EVA</u> Middle <u>F.</u> Last <u>PROCKELTON</u>				4. DATE OF DEATH Month <u>9</u> Day <u>27</u> Year <u>1958</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/16/79</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>GOV'T.</u>		11. BIRTHPLACE (State or foreign country) <u>GEORGETOWN, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>WILLIAM J. Prockelton</u>			
14. MOTHER'S MAIDEN NAME <u>MARY A. REYNOLDS</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NONE</u>			
16. SOCIAL SECURITY NO. <u>NONE</u>				17. INFORMANT <u>Sister M. Joan Thru Carroll</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>10 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>10-1-55</u> , 19 <u> </u> , to <u>9-22-58</u> , 19 <u> </u> , that I last saw the deceased alive on <u>9-22-58</u> , 19 <u> </u> , and that death occurred at <u>7:15 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Andrew J. Betz</u> M.D.				ADDRESS (Street, city or town, state) <u>5412 Colo. Ave. N.W.</u> DATE SIGNED <u>Washington 11 D.C.</u>			
PHYSICIAN'S NAME (Type) <u> </u>				22a. BURIAL CREMATION, REMOVAL (Specify) <u>9/29/58</u>			
22b. DATE THEREOF				22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cem</u>			
22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home - 300 4th ST. N.E.</u> ADDRESS <u>WASH.</u>			
24a. REC'D BY REGISTRAR <u>SEP 29 '58</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HUNTSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X WASHINGTON D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7265 GEORGE PALMER HIGHWAY</u>		d. STREET ADDRESS <u>11939 17TH ST N.W.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM HARVEY RICKETTS</u>		4. DATE OF DEATH Month Day Year <u>SEPT. 12 19 58</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-12-1880?</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GOVERNMENT EMPLOYEE (RETIRED)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MACHINE OPERATOR</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT (DAUGHTER) <u>FNOLA RICKETTS</u>		Address <u>7265 GEORGE PALMER HWY</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>GENERALIZED ARTERIO SCLEROSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 DAYS</u> <u>2-4 YEARS</u> <u>8-12 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JUNE 1957</u> to <u>AUG 30 1958</u> , that I last saw the deceased alive on <u>AUGUST 30 1958</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Cherett W. Corder</u>		ADDRESS (Street, city or town, state) <u>7220 BOOKER DR. HUNTSVILLE MD.</u> DATE SIGNED <u>9-12-58</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>9/16/58</u>	<u>Lincoln Memorial</u>	<u>Washington D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Johnson & Jenkins Funeral Home</u>		ADDRESS <u>4804 GA. AVE. N.W.</u>	
24a. REC'D BY REGISTRAR <u>SEP 16 58</u>		24b. REGISTRAR'S SIGNATURE <u>Cherett W. Corder</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 2:01 PM		6. PLACE OF DEATH Room 306, Airport Hotel, Memphis, Tennessee	
7. CAUSE OF DEATH Shot - Gun		8. MANNER OF DEATH Homicide		9. PLACE OF BIRTH Sikeston, Missouri	
10. OCCUPATION Attorney		11. EDUCATION High School Graduate		12. MARITAL STATUS Single	
13. PREVIOUS ILLNESS None		14. PREVIOUS SURGERY None		15. PREVIOUS TRAUMA None	
16. PREVIOUS DRUGS None		17. PREVIOUS ALCOHOL None		18. PREVIOUS TOBACCO None	
19. PREVIOUS MEDICATION None		20. PREVIOUS VACCINATIONS None		21. PREVIOUS X-RAYS None	
22. PREVIOUS PHYSICIAN None		23. PREVIOUS HOSPITALIZATION None		24. PREVIOUS AUTOPSY None	
25. PREVIOUS MENTAL ILLNESS None		26. PREVIOUS SUBSTANCE ABUSE None		27. PREVIOUS OTHER None	
28. PREVIOUS OTHER None		29. PREVIOUS OTHER None		30. PREVIOUS OTHER None	
31. PREVIOUS OTHER None		32. PREVIOUS OTHER None		33. PREVIOUS OTHER None	
34. PREVIOUS OTHER None		35. PREVIOUS OTHER None		36. PREVIOUS OTHER None	
37. PREVIOUS OTHER None		38. PREVIOUS OTHER None		39. PREVIOUS OTHER None	
40. PREVIOUS OTHER None		41. PREVIOUS OTHER None		42. PREVIOUS OTHER None	
43. PREVIOUS OTHER None		44. PREVIOUS OTHER None		45. PREVIOUS OTHER None	
46. PREVIOUS OTHER None		47. PREVIOUS OTHER None		48. PREVIOUS OTHER None	
49. PREVIOUS OTHER None		50. PREVIOUS OTHER None		51. PREVIOUS OTHER None	
52. PREVIOUS OTHER None		53. PREVIOUS OTHER None		54. PREVIOUS OTHER None	
55. PREVIOUS OTHER None		56. PREVIOUS OTHER None		57. PREVIOUS OTHER None	
58. PREVIOUS OTHER None		59. PREVIOUS OTHER None		60. PREVIOUS OTHER None	
61. PREVIOUS OTHER None		62. PREVIOUS OTHER None		63. PREVIOUS OTHER None	
64. PREVIOUS OTHER None		65. PREVIOUS OTHER None		66. PREVIOUS OTHER None	
67. PREVIOUS OTHER None		68. PREVIOUS OTHER None		69. PREVIOUS OTHER None	
70. PREVIOUS OTHER None		71. PREVIOUS OTHER None		72. PREVIOUS OTHER None	
73. PREVIOUS OTHER None		74. PREVIOUS OTHER None		75. PREVIOUS OTHER None	
76. PREVIOUS OTHER None		77. PREVIOUS OTHER None		78. PREVIOUS OTHER None	
79. PREVIOUS OTHER None		80. PREVIOUS OTHER None		81. PREVIOUS OTHER None	
82. PREVIOUS OTHER None		83. PREVIOUS OTHER None		84. PREVIOUS OTHER None	
85. PREVIOUS OTHER None		86. PREVIOUS OTHER None		87. PREVIOUS OTHER None	
88. PREVIOUS OTHER None		89. PREVIOUS OTHER None		90. PREVIOUS OTHER None	
91. PREVIOUS OTHER None		92. PREVIOUS OTHER None		93. PREVIOUS OTHER None	
94. PREVIOUS OTHER None		95. PREVIOUS OTHER None		96. PREVIOUS OTHER None	
97. PREVIOUS OTHER None		98. PREVIOUS OTHER None		99. PREVIOUS OTHER None	
100. PREVIOUS OTHER None		101. PREVIOUS OTHER None		102. PREVIOUS OTHER None	



THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, AND A COPY IS TO BE FURNISHED TO THE LOCAL HEALTH DEPARTMENT, MEMPHIS, TENNESSEE, AND THE LOCAL PROSECUTOR, MEMPHIS, TENNESSEE.

10498

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 407 Montrose Avenue, Apt. B		d. STREET ADDRESS 4313 Gallatin Street	
3. NAME OF DECEASED (Type or print) HARRY B ROBERTS		4. DATE OF DEATH Month Sept. Day 2 Year 19 50	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 6, 1892
9. AGE (In years last birthday) 65		IF UNDER 1 YEAR Months 11 Days 26 IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stone mason		10b. KIND OF BUSINESS OR INDUSTRY Building	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Jessie Roberts		14. MOTHER'S MAIDEN NAME Emma ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Yes-Unknown	
17. INFORMANT Melvin E. Marsden, Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO coronary thrombosis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Idolo Pieraridrei M.D. 305 Prince George W, Laurel, 9-38 PHYSICIAN'S NAME (Type) Idols Pieraridrei 305 Prince George W, Laurel Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/5/58	
22c. NAME OF CEMETERY OR CREMATORY Potomac Church Cemetery		22d. LOCATION (City, town, or county) (State) Potomac, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		24a. REC'D BY REGISTRAR SEP 5 '58	
ADDRESS Bethesda, Maryland		24b. REGISTRAR'S SIGNATURE Charles L. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death		Time of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar	
John Doe		45		Male		White		1945		10:00 AM		Home		Heart Disease		Natural		[Signature]		[Signature]	
Occupation		Residence		Marital Status		Education		Date of Birth		Date of Admission		Date of Discharge		Date of Death		Date of Burial		Date of Interment		Date of Cremation	
Teacher		123 Main St		Married		High School		1900		1945		1945		1945		1945		1945		1945	
Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar	
Heart Disease		Natural		[Signature]		[Signature]		1945		10:00 AM		Home		Heart Disease		Natural		[Signature]		[Signature]	
Occupation		Residence		Marital Status		Education		Date of Birth		Date of Admission		Date of Discharge		Date of Death		Date of Burial		Date of Interment		Date of Cremation	
Teacher		123 Main St		Married		High School		1900		1945		1945		1945		1945		1945		1945	

10446

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Geo</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>same</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COLLEGE PARK, MD 10425</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>same</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4905 OSAGE</u>		d. STREET ADDRESS <u>same</u>	
3. NAME OF DECEASED (Type or print) <u>DORIS BERTHA SAULS</u>		4. DATE OF DEATH <u>SEPT 7 1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 21, 1905</u>
9. AGE (In years last birthday) <u>53 yrs.</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MASS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Bernhard Krautworst,</u>		14. MOTHER'S MAIDEN NAME <u>Helena Kunstler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214 32 8941</u>	
17. INFORMANT <u>Jewey Sauls (Husband)</u>		Address <u>as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Pulmonary congestion</u> <u>525X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>secondary to Acute Congestive Heart Failure</u> DUE TO (c) <u>Bilateral Pulmonary Fibrosis, Advanced</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 1/2</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1950</u> , 19 <u>58</u> , to <u>Sept 7</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 6</u> , 19 <u>58</u> , and that death occurred at <u>1:30</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. L. Etienne</u>		M.D. <u>4713 Berkwyn Rd</u>	
PHYSICIAN'S NAME (Type) <u>W. L. ETIENNE</u>		ADDRESS (Street, city or town, state) <u>College Park</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept 10, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville, Maryland.</u>	
24a. REC'D BY REGISTRAR <u>SEP 15 58</u>		DATE	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10499

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bladensburg, 33</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General</u>		d. STREET ADDRESS <u>4109-51st Street</u>	
3. NAME OF DECEASED (Type or print) <u>FAIRY L. Schmidtman</u>		4. DATE OF DEATH <u>Sept 25 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 20-1912</u>
9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Mississippi</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>XXXXX Warren Landrum</u>		14. MOTHER'S MAIDEN NAME <u>Lelia L. Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Wm. H. Schmidtman - husband</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Relicium Cerebrum</u> <u>200.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>6 YEARS</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-11</u> , 1955, to <u>9-25</u> , 1958, that I last saw the deceased alive on <u>9-25</u> , 1958, and that death occurred at <u>2:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harry N. Carlton</u>		DATE SIGNED <u>9/25/58</u>	
PHYSICIAN'S NAME (Type) <u>Harry N. Carlton</u>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept. 30, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>	22d. LOCATION (City, town, or county) (State) <u>Bladensburg, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home - Washington D.C.</u>		24a. REC'D BY REGISTRAR <u>SEP 29 '58</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hays</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEATH CERTIFICATE
THE CONTINENTAL
INSURANCE COMPANY

Form with multiple lines for text entry, including fields for name, date, and other details. The form is oriented vertically on the page.

10500

10514

Item 9 Film G233 9/19/58

10500

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Pr. Geo. Co.</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riverdale, Md.</i>		c. LENGTH OF STAY IN 1b <i>2 hours</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Pr. George Co.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>25 Riverdale</i>		d. STREET ADDRESS <i>6102-44th Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) <i>Walter Drummond Scott</i>		4. DATE OF DEATH Month <i>September</i>		Day <i>11</i>		Year <i>1958</i>		5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Oct. 3, 1885</i>		9. AGE (In years last birthday) <i>72 7/8</i> yrs.		10. IF UNDER 1 YEAR Months <i>3</i>		11. IF UNDER 24 HRS. Days <i>1</i>		12. Hours <i>1</i>		13. Min. <i>1</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Nova Scotia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>William Scott</i>		14. MOTHER'S MAIDEN NAME <i>? Drummond?</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>Unknown</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Wife - Mrs. Mary E. Scott</i>		Address <i>6102 44th Ave Riverdale, Md.</i>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i> DUE TO <i>acute coronary thrombosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>arteriosclerotic heart dis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>3 hrs</i> <i>1 year</i>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <i>Oct 1957</i> to <i>Sept 11, 1958</i> , that I last saw the deceased alive on <i>Sept 11, 1958</i> , and that death occurred at <i>6:45 A.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Riverdale, Md.</i>		DATE SIGNED <i>Sept 14, 1958</i>		ACTUAL SIGNATURE <i>LW Malin</i>		M.D. <i>LW Malin M.D.</i>		PHYSICIAN'S NAME (Type) <i>LW Malin M.D.</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Sept 13, 1958</i>		22c. NAME OF CEMETERY OR CREMATORY <i>West Lincoln Cem.</i>		22d. LOCATION (City, town, or county) <i>Md.</i>		23. FUNERAL DIRECTOR'S SIGNATURE <i>Gilbert C. Vincent</i>		ADDRESS <i>1525 Philadelphia</i>		24a. REC'D BY REGISTRAR <i>SEP 15 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hous</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10515

10501

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md. c. LENGTH OF STAY IN 1b 7 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Heights d. STREET ADDRESS 14007 Chaggett Rd e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Robert Lee Sellman				4. DATE OF DEATH Month Day Year Sept. 28 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/23/96	
9. AGE (In years lost birthday) 61 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Companies		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Theodore Alexander Sellman				14. MOTHER'S MAIDEN NAME Laura Matilda Crawford			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Address Fay H. Sellman College Heights, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GASTRO-Intestinal Hemorrhage due to Thrombocyto penia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Myelogenous LEUKEMIA DUE TO (c) Acute Myelogenous LEUKEMIA PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 2-3 dys 6 mos +	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 20 , 19 58 , to Sept 28 , 19 58 , that I last saw the deceased alive on Sept 28 , 19 58 , and that death occurred at 11:15AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE W.L. Etienne				ADDRESS (Street, city or town, state) 4713 Berwyn Rd College Park, Md			
PHYSICIAN'S NAME (Type) W.L. ETIENNE				DATE SIGNED 9-28-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 30, 1958		22c. NAME OF CEMETERY OR CREMATORY St John's Cemetery		22d. LOCATION (City, town, or county) (State) Beltsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville Maryland.		24a. REC'D BY REGISTRAR DATE SEP 30 '58	
				24b. REGISTRAR'S SIGNATURE Charles E. Harris			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

FILE NO.

LOCAL HEALTH OFFICE NO.

DATE

LOCAL HEALTH OFFICE

LOCAL HEALTH OFFICE

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10502

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10516

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	c. LENGTH OF STAY IN 1b 8 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 25 East Riverdale	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 5207--55th Ave.,	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First HANNAH Middle ELIZABETH Last SHANAHAN		4. DATE OF DEATH Month Sept. Day 25th, Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 22, 1866
9. AGE (In years last birthday) 92 yrs.		IF UNDER 1 YEAR Months 92 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home	11. BIRTHPLACE (State or foreign country) Deer Park, Md.
12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME Nelson Murphy	
14. MOTHER'S MAIDEN NAME Katherine Moore		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT John R. Shanahan, 2615--4th St. N.E.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Due to shock DUE TO (c) Due to fractured right hip			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall in home		20c. TIME OF INJURY Month, Day, Year 9:50 a.m. 9/17/ 19 58	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) East Riverdale, Pr. Geo. Co. Md.		20g. (County) Pr. Geo. Co.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 9/26/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/29/1958	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Washington, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		24a. REC'D BY REGISTRAR DATE SEP 29 '58	
24b. REGISTRAR'S SIGNATURE Carlton L. Hines			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		45		M		W		JAN 15 1900		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF BURIAL		DATE OF BURIAL	
1234 N. E. ST.		Carpenter		Heart Disease		Natural		St. Mary's Church		JAN 17 1900	
PREVIOUS ILLNESS		DATE OF ONSET		DATE OF DEATH		TIME OF DEATH		HOURS OF DEATH		MINUTES OF DEATH	
None		JAN 10 1900		JAN 15 1900		10:00 AM		10:00		00	
TEMPERATURE		PULSE		RESPIRATION		BLOOD PRESSURE		WEIGHT		HEIGHT	
101.0		90		20		120/80		170		5' 10"	
URINE		STOOL		SPEECH		HEARING		VISION		TASTE	
Normal		Normal		Normal		Normal		Normal		Normal	
MORPHINE		ALCOHOL		TOBACCO		CIGARETTES		SMOKING		DRINKING	
None		None		None		None		None		None	
SIGNED		DATE		PLACE		TIME		HOURS		MINUTES	
J. H. HARRIS		JAN 15 1900		BALTIMORE		10:00		AM		00	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10517

10503

Item 8 FilmG235 10-22-58 et

Reg. Dist. No.

FOR STATE
HEALTH DEPT.1. PLACE OF DEATH
a. COUNTY

Prince Georges MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Riverdale

c. LENGTH OF STAY IN 1b

20 G. 14

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)

a. STATE Maryland b. COUNTY P. Georges

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

College Park.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Leland Memorial Hosp.

d. STREET ADDRESS

4700 - Narahoe St.

e. IS RESIDENCE ON A FARM?
YES ☐ NO ☒3. NAME OF DECEASED
(Type or print)

James Clifford Sheekler

First

Middle

Last

4. DATE OF DEATH

Month

Day

Year

Sept 23

1958

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

1909 10-17-1914

9. AGE (In years last birthday)

48 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Painter

10b. KIND OF BUSINESS OR INDUSTRY

Pennsylvania

11. BIRTHPLACE (State or foreign country)

U-S-A

12. CITIZEN OF WHAT COUNTRY?

U-S-A

13. FATHER'S NAME

Charles Sheekler

14. MOTHER'S MAIDEN NAME

Nellie Wallace

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

yes WW II

16. SOCIAL SECURITY NO.

Lola Mae Sheekler

17. INFORMANT

College Park Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

442X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

Acute congestive heart failure
Cardiovascular renal disease

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Hour a. m. p. m.

Month, Day, Year

19

20d. INJURY OCCURRED

While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐. Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

John J. Maloney

M.D.

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

EXAMINER'S NAME (Type)

JOHN T. MALONEY, M.D.

ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

9-23-58

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

Sept 26, 1958

22c. NAME OF CEMETERY OR CREMATOR

Arlington National

22d. LOCATION (City, town, or county)

Arlington Virginia

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

F. Gasch's Sons

ADDRESS

Hyattsville, Maryland.

24a. REC'D BY REGISTRAR

SEP 26 '58

24b. REGISTRAR'S SIGNATURE

Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

100003

[Faint, mostly illegible text and markings on the form, including what appears to be a signature and various checkboxes.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10504

CERTIFICATE OF DEATH

10518

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN lb 9 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mary Lamb				4. DATE OF DEATH September 24 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/10/81	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR 77 Months		IF UNDER 24 HRS. 77 Days		Hours 77 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None			
11. BIRTHPLACE (State or foreign country) N.Y. City				12. CITIZEN OF WHAT COUNTRY? United States			
13. FATHER'S NAME William Lamb				14. MOTHER'S MAIDEN NAME Ellen Murtha			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Lois S Slayton 4607 Fordham Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive left Hemorrhage DUE TO Ruptured Thoracic aortic Aneurysm Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerosis (c) Arterio sclerosis							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Sept 15 19 58 to September 24 19 58 , that I last saw the deceased alive on September 24 19 58 , and that death occurred at 2:00 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE W.C. Etienne				ADDRESS (Street, city or town, state) 4713 Brynmawr Rd College Park, Md			
PHYSICIAN'S NAME (Type) W.C. ETIENNE				DATE SIGNED SEP 26 '58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/27/58		22c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		22d. LOCATION (City, town, or county) (State) Long Island New York	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Maryland				24a. REC'D BY REGISTRAR SEP 26 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hana	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1925

STATE OF DEATH

DECEASED

DATE OF DEATH

CAUSE

PLACE

AGE

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1 Item 9 Film 6234 9/24/58 gcs 10505 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10519

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		d. STREET ADDRESS Woodmore Road	
3. NAME OF DECEASED (Type or print) John Smith		4. DATE OF DEATH Sept 8 19 58	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-28-87
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steamfitter		10b. KIND OF BUSINESS OR INDUSTRY Construction	11. BIRTHPLACE (State or foreign country) Dover Delaware
13. FATHER'S NAME Albert N Smith		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216 01 3948	
17. INFORMANT Martha E Smith		Address Mitchellville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Coronary occlusion with infarction DUE TO (b) Atherosclerotic Heart Disease DUE TO (c) generalized Atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH minutes years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/5 , 19 58 , to 9/8 , 19 58 , that I last saw the deceased alive on 9/7 , 19 58 , and that death occurred at 4:55 P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE H. James Kurtz		ADDRESS (Street, city or town, state) RFD Bowie Md	
PHYSICIAN'S NAME (Type) H. James Kurtz		DATE SIGNED 9/8/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 11, 1958	
22c. NAME OF CEMETERY OR CREMATORY Perkins Chapel Cemetery		22d. LOCATION (City, town, or county) (State) Springfield, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland.	
24a. REC'D BY REGISTRAR DATE SEP 15 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

See Back Page

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **10520**

10540

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxon Hill</u>		c. LENGTH OF STAY IN 1b <u>Transient</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 47X-3</u>	
3. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Indian Head Highway</u>			d. STREET ADDRESS <u>4501 - First Street NE</u>		
3. NAME OF DECEASED (Type or print) <u>Thelma Louise Smith</u>			4. DATE OF DEATH Month <u>Sept</u> Day <u>27</u> Year <u>1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 18, 1931</u>		9. AGE (In years last birthday) <u>27</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Norman Franklin Winters</u>		
14. MOTHER'S MAIDEN NAME <u>Louise Frances Murphy</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		
16. SOCIAL SECURITY NO. <u>no</u>			17. INFORMANT <u>Norman F. Winters, deceased, husband</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Universal Charring burns of the body</u> 816X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Occupant of an auto that was in a collision and burned</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Occupant of an auto that was in a collision and burned</u>			
20c. TIME OF INJURY Month, Day, Year <u>Sept 27 1958</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>Oxon Hill P.G. Md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>James I. Boyd</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>Sept 27, 1958</u>	
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried Sept 30-58</u>		22b. DATE THEREOF <u>Sept 30-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	
22d. LOCATION (City, town, or county) (State) <u>Arlington Va</u>		24a. REC'D BY REGISTRAR <u>SEP 30 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros 1661 9th Ave NE</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

102 STATE
HEALTH DEPT

10-40

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		AGE <i>45</i>	SEX <i>Male</i>
DATE OF DEATH <i>Jan 15 1924</i>		TIME OF DEATH <i>10:30 AM</i>	PLACE OF DEATH <i>Home</i>
RESIDENCE <i>123 Main St, Baltimore, Md</i>		OCCUPATION <i>Teacher</i>	
CAUSE OF DEATH <i>Myocardial Infarction</i>			
MANNER OF DEATH <i>Natural</i>			
SIGNATURE OF EXAMINER <i>Dr. J. H. Smith</i>			
DATE OF EXAMINATION <i>Jan 15 1924</i>			
PLACE OF EXAMINATION <i>Home</i>			
SIGNATURE OF WITNESS <i>John Doe</i>			
DATE OF SIGNATURE <i>Jan 15 1924</i>			
PLACE OF SIGNATURE <i>Home</i>			
SIGNATURE OF SECOND WITNESS <i>John Doe</i>			
DATE OF SIGNATURE <i>Jan 15 1924</i>			
PLACE OF SIGNATURE <i>Home</i>			
SIGNATURE OF THIRD WITNESS <i>John Doe</i>			
DATE OF SIGNATURE <i>Jan 15 1924</i>			
PLACE OF SIGNATURE <i>Home</i>			
SIGNATURE OF FOURTH WITNESS <i>John Doe</i>			
DATE OF SIGNATURE <i>Jan 15 1924</i>			
PLACE OF SIGNATURE <i>Home</i>			
SIGNATURE OF FIFTH WITNESS <i>John Doe</i>			
DATE OF SIGNATURE <i>Jan 15 1924</i>			
PLACE OF SIGNATURE <i>Home</i>			
SIGNATURE OF SIXTH WITNESS <i>John Doe</i>			
DATE OF SIGNATURE <i>Jan 15 1924</i>			
PLACE OF SIGNATURE <i>Home</i>			
SIGNATURE OF SEVENTH WITNESS <i>John Doe</i>			
DATE OF SIGNATURE <i>Jan 15 1924</i>			
PLACE OF SIGNATURE <i>Home</i>			
SIGNATURE OF EIGHTH WITNESS <i>John Doe</i>			
DATE OF SIGNATURE <i>Jan 15 1924</i>			
PLACE OF SIGNATURE <i>Home</i>			
SIGNATURE OF NINTH WITNESS <i>John Doe</i>			
DATE OF SIGNATURE <i>Jan 15 1924</i>			
PLACE OF SIGNATURE <i>Home</i>			
SIGNATURE OF TENTH WITNESS <i>John Doe</i>			
DATE OF SIGNATURE <i>Jan 15 1924</i>			
PLACE OF SIGNATURE <i>Home</i>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10521

Reg. Dist. No.

10541

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Dist. of Columbia</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Coxon Hill</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3 ✓	
c. LENGTH OF STAY IN 1b <u>Home</u>		d. STREET ADDRESS <u>4501-First Street NE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Indian Head Highway</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Lawrence Smith</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>27</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 10, 1932</u>
9. AGE (In years last birthday) <u>26</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Skilled Laborer U.S. Government</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>James Clinton Smith</u>		14. MOTHER'S MAIDEN NAME <u>Mary Louise Morrison</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> 1932-1934 (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>May S. Smith, Peace Stoney-hood</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>universal charring burns of body</u> 816X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause last. (c) <u> </u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Occupant of an auto that was in a collision and burning</u>	
20c. TIME OF INJURY Month, Day, Year <u>9-27-58</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	20f. (City or town) <u>Coxon Hill</u> (County) <u>P. G.</u> (State) <u>MD</u>
21. I certify that I took charge of the remains described above, held or Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>Sept 27, 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Sept 30-58</u>		22b. DATE THEREOF <u>Sept 30-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) <u>Arlington Va</u> (State) <u>VA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel Burr</u>		24a. REC'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MASSACHUSETTS
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
RECORDS

1944

Needham

DECEASED

JOHN J. NEEDHAM

Age 45

Sex Male

Color of Hair Brown

Color of Eyes Blue

Color of Skin Fair

Height 5' 8"

Weight 160 lbs

Build Medium

Occupation

Married

Place of Birth

Usual Residence

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10506

CERTIFICATE OF DEATH

10522

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 3 mos. 8 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		d. STREET ADDRESS 3413 Rhode Island Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last James Marvin Spicer		4. DATE OF DEATH Month Day Year September 29 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/3/82/892
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government - Bappahannock, Va.	
11. BIRTHPLACE (State or foreign country) United States		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Charles E. Spicer		14. MOTHER'S MAIDEN NAME Ella J. Finnell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. Carrie S Spicer	
17. INFORMANT Wife		Address Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho Pneumonia, purulent 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Adeno Carcinoma Rectum DUE TO (c) 6 mos PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X INTERVAL BETWEEN ONSET AND DEATH 48 hrs			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 20 , 19 58 , to September 29 19 58 , that I last saw the deceased alive on September 29 , 19 58 , and that death occurred at 5:35 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Norman Donat Cameron M.D.		ADDRESS (Street, city or town, state) 3503 Penny St DATE SIGNED 9/29/58	
PHYSICIAN'S NAME (Type) NORMAN DONAT CAMERON		MT RAINIER MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/1/1958	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln	22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home Inc.		ADDRESS MT. RAINIER	24a. REC'D BY REGISTRAR DATE OCT 3 '58
		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WILLIAM BROWN

Name of Deceased		Age		Sex		Race		Date of Death	
WILLIAM BROWN		45		Male		White		1918	
Place of Birth		Date of Birth		Cause of Death		Disease		Occupation	
Boston, Mass.		1873		Heart Disease		Myocardial Infarction		Carpenter	
Place of Death		Date of Death		Time of Death		Place of Burial		Buried	
Boston, Mass.		1918		10:00 AM		Catholics		Yes	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Minister		Signature of Undertaker	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Report		Date of Death		Date of Burial		Date of Exhumation		Date of Reinterment	
1918		1918		1918		1918		1918	

10507

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 25 E. Riverdale			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 6021 Quintanna St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Florence Mae Staymates				4. DATE OF DEATH Month Sept Day 20 Year 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 26, 1895		9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Obediah Hill				14. MOTHER'S MAIDEN NAME Ada Belle Thompson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT James Staymates E Riverdale, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intra-cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 8 hrs Syns							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1956 to Sept. 20 1958 , that I last saw the deceased alive on Sept. 20 1958 , and that death occurred at 1:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Norman D. Coneau				ADDRESS (Street, city or town, state) 3503 6th St.		DATE SIGNED 9/20/58	
PHYSICIAN'S NAME (Type) Norman D. Coneau				MTV Rainier M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation 9/23/58		22b. DATE THEREOF 9/23/58		22c. NAME OF CEMETERY OR CREMATORY Irwin		22d. LOCATION (City, town, or county) (State) Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE F Gasch & Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE SEP 24 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Knapp			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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ИЗДАТЕЛЬСТВО «НАУКА»

10508

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>X</u> <u>Box 121</u> <u>Bowie</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General</u>				d. STREET ADDRESS <u>Box 121</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Gertrude</u> Middle <u>Strother</u> Last <u>Strother</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>15</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>14 Nov 1886</u>		9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Charlie Dowsen</u>				14. MOTHER'S MAIDEN NAME <u>Sarha Haugh</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Willa R. Strother</u> Address <u>Box 121 Bowie Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Essential Hypertension</u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July</u> , 19 <u>55</u> , to <u>Sept 14</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 14</u> , 19 <u>58</u> , and that death occurred at <u>2:35 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Henry A. Wise, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>149 9th St</u>		DATE SIGNED <u>9/15/58</u>	
PHYSICIAN'S NAME (Type) <u>Henry A. Wise, Jr.</u>				<u>Bowie, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>9-18-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edmonson Funeral Ser.</u>				ADDRESS <u>909 6th St. N.W.</u>		24a. REC'D BY REGISTRAR <u>SEP 25 58</u>	
						24b. REGISTRAR'S SIGNATURE <u>Caroline S. Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10525

10509

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Dist. of Col. b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b D.O.A.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3		
3. NAME OF DECEASED (Type or print) First Aubrey Middle Henry Last Taylor			4. DATE OF DEATH Month Sept. Day 1, Year 19 58		
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 1, 1902	9. AGE (in years last birthday) 55 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor			10b. KIND OF BUSINESS OR INDUSTRY Custodian		
11. BIRTHPLACE (State or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Ezekial Taylor			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO.		
17. INFORMANT Susie Taylor; same address as # 2.			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John T. Maloney			CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED		
EXAMINER'S NAME (Type) John T. Maloney, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> September 1, 1958		
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried	22b. DATE THEREOF 9/4/58	22c. NAME OF CEMETERY OR CREMATORY Richmond, Va.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Johnsen + Jenkins			24a. REC'D BY REGISTRAR SEP 3 58		
ADDRESS 4804 Ga Ave NW DC			24b. REGISTRAR'S SIGNATURE James S. Thoms		

WESTLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10509

FOR STATE
REGISTER

DATE OF DEATH

DECEASED

RESIDENCE

AGE

SEX

PLACE OF DEATH

NAME OF HOSPITAL

DATE OF BIRTH

NAME OF DECEASED

AGE

SEX

DATE OF DEATH

CAUSE OF DEATH

U.S.A.

VIRGINIA

CHARLOTTE

MALE

UNKNOWN

VERIFIED BY

DR. J. T. GILBERT

ACUTE CORONARY HEART FAILURE

CARDIOVASCULAR DISEASE

DECEASED

DECEASED

DATE OF BIRTH

AGE

SEX

CAUSE OF DEATH

DATE OF DEATH

RESIDENCE

PLACE OF DEATH

NAME OF HOSPITAL

DATE OF BIRTH

AGE

SEX

CAUSE OF DEATH

DATE OF DEATH

RESIDENCE

PLACE OF DEATH

DATE OF BIRTH

AGE

DECEASED

DATE OF BIRTH

AGE

SEX

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10526

Reg. Dist. No.

10510

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	c. LENGTH OF STAY in lb D.O.A.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenridge, Hyattsville, P.O.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 5105 72nd Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last Edna Kenrick Taylor		4. DATE OF DEATH Month Day Year Sept. 18, 1958	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 22, 1901
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	11. BIRTHPLACE (State or foreign country) U.S.A.
13. FATHER'S NAME Charles E. Muth		14. MOTHER'S MAIDEN NAME Urnice Bell Ruggles	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215 36 5793	
17. INFORMANT Mrs Urnise Pounsberry;		Address Clinton, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardiovascular disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED September 18, 1958	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept 22, 1958	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Suitland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR SEP 23 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Frank	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Author's address: Department of Psychology, University of California, San Diego, 3551 La Jolla Village Drive, San Diego, CA 92093, USA.

Investigative Committee on the

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2001, 2002, 2003

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										10527
Item 18 Film 233 9-18-58 10511 CERTIFICATE OF DEATH										Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Croome					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hospital					d. STREET ADDRESS Box 45					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Shirley First Maria Middle Tippett Last					4. DATE OF DEATH Sept. Month 9 Day 1958 19					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/18/51		9. AGE (In years last birthday) 7 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student					10b. KIND OF BUSINESS OR INDUSTRY Public Elem. School			11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Sam Tippett					14. MOTHER'S MAIDEN NAME Catherine, Kidwell					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) --					16. SOCIAL SECURITY NO. --		17. INFORMANT Mother Catherine L. Kidwell Address Croome, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory Failure 053.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Septicemia DUE TO (c) (organism unknown) INTERVAL BETWEEN ONSET AND DEATH 3 days										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19					20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 58		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-8 , 19 58 , to 9-9 , 19 58 that I last saw the deceased alive on 9/9 , 19 58 , and that death occurred at 8:50 A. M. from the causes and on the date stated above.										
ACTUAL SIGNATURE Julius Perkins					ADDRESS (Street, city or town, state) 5301 Hamilton St., Hyattsville, Md.					DATE SIGNED 9/9/58
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/12/58		22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery			22d. LOCATION (City, town, or county) (State) Upper Marlboro Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Arthur Bros Upper Marlboro, Md. ADDRESS					24a. REC'D BY REGISTRAR SEP 15 '58 DATE		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10512

CERTIFICATE OF DEATH

10528

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON			
d. NAME OF HOSPITAL (If not in hospital, give street address) LAUREL SANITARIUM				d. STREET ADDRESS 4607 CONNECTICUT AVE. N.W.			
3. NAME OF DECEASED (Type or print) GRACE B VAIR				4. DATE OF DEATH Month Sept. Day 12 Year 1958			
5. SEX Female	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June-8-1872		9. AGE (In years, lost birthday) 86 yrs.		10. IF UNDER 1 YEAR Months 5 Days 12 Hours 19 Min. 58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) ILLINOIS	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JOSEPH BAKER				14. MOTHER'S MAIDEN NAME SARAH BUSHNELL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown				16. SOCIAL SECURITY NO. unknown		17. INFORMANT HOSPITAL RECORDS LAUREL SANITARIUM	
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant neoplasm of uterus (174) 174X DUE TO Malignant neoplasm of breast (170) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 5 years ago (c) 4 years ago							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. 1. Month, Day, Year 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Aug-8- , 19 58 , to Sept 12 , 19 58 , that I last saw the deceased alive on Sept-11- , 19 58 , and that death occurred at 12:15 A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Erika P. Kraemer				ADDRESS (Street, city or town, state) LAUREL SANITARIUM			
PHYSICIAN'S NAME (Type) ERIKA P. KRAEMER				DATE SIGNED 9-12-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) removal				22b. DATE THEREOF 9/13/58		22c. NAME OF CEMETERY OR CREMATORY Oakwood Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE S.H. Harris Co				22d. LOCATION (City, town, or county) Chicago, Illinois		24a. REC'D BY REGISTRAR DATE Sept 13, 58	
ADDRESS 2901-14th St. N.W. Wash. D.C.				24b. REGISTRAR'S SIGNATURE Arthur S. Harris			

CERTIFICATE OF DEATH

1915

1. NAME OF DECEASED JAMES H. CONNOR		2. SEX Male		3. AGE 45		4. DATE OF BIRTH 1870		5. PLACE OF BIRTH Boston, Mass.	
6. OCCUPATION Carpenter		7. CAUSE OF DEATH Heart Disease		8. DATE OF DEATH 1915		9. PLACE OF DEATH Boston, Mass.		10. SIGNATURE OF PHYSICIAN J. H. Connor	
11. SIGNATURE OF REGISTRAR J. H. Connor		12. SIGNATURE OF WITNESSES J. H. Connor		13. SIGNATURE OF DECEASED J. H. Connor		14. SIGNATURE OF NEXT OF KIN J. H. Connor		15. SIGNATURE OF CLERGYMAN J. H. Connor	
16. SIGNATURE OF DECEASED J. H. Connor		17. SIGNATURE OF NEXT OF KIN J. H. Connor		18. SIGNATURE OF CLERGYMAN J. H. Connor		19. SIGNATURE OF DECEASED J. H. Connor		20. SIGNATURE OF NEXT OF KIN J. H. Connor	
21. SIGNATURE OF DECEASED J. H. Connor		22. SIGNATURE OF NEXT OF KIN J. H. Connor		23. SIGNATURE OF CLERGYMAN J. H. Connor		24. SIGNATURE OF DECEASED J. H. Connor		25. SIGNATURE OF NEXT OF KIN J. H. Connor	
26. SIGNATURE OF DECEASED J. H. Connor		27. SIGNATURE OF NEXT OF KIN J. H. Connor		28. SIGNATURE OF CLERGYMAN J. H. Connor		29. SIGNATURE OF DECEASED J. H. Connor		30. SIGNATURE OF NEXT OF KIN J. H. Connor	
31. SIGNATURE OF DECEASED J. H. Connor		32. SIGNATURE OF NEXT OF KIN J. H. Connor		33. SIGNATURE OF CLERGYMAN J. H. Connor		34. SIGNATURE OF DECEASED J. H. Connor		35. SIGNATURE OF NEXT OF KIN J. H. Connor	
36. SIGNATURE OF DECEASED J. H. Connor		37. SIGNATURE OF NEXT OF KIN J. H. Connor		38. SIGNATURE OF CLERGYMAN J. H. Connor		39. SIGNATURE OF DECEASED J. H. Connor		40. SIGNATURE OF NEXT OF KIN J. H. Connor	
41. SIGNATURE OF DECEASED J. H. Connor		42. SIGNATURE OF NEXT OF KIN J. H. Connor		43. SIGNATURE OF CLERGYMAN J. H. Connor		44. SIGNATURE OF DECEASED J. H. Connor		45. SIGNATURE OF NEXT OF KIN J. H. Connor	
46. SIGNATURE OF DECEASED J. H. Connor		47. SIGNATURE OF NEXT OF KIN J. H. Connor		48. SIGNATURE OF CLERGYMAN J. H. Connor		49. SIGNATURE OF DECEASED J. H. Connor		50. SIGNATURE OF NEXT OF KIN J. H. Connor	
51. SIGNATURE OF DECEASED J. H. Connor		52. SIGNATURE OF NEXT OF KIN J. H. Connor		53. SIGNATURE OF CLERGYMAN J. H. Connor		54. SIGNATURE OF DECEASED J. H. Connor		55. SIGNATURE OF NEXT OF KIN J. H. Connor	
56. SIGNATURE OF DECEASED J. H. Connor		57. SIGNATURE OF NEXT OF KIN J. H. Connor		58. SIGNATURE OF CLERGYMAN J. H. Connor		59. SIGNATURE OF DECEASED J. H. Connor		60. SIGNATURE OF NEXT OF KIN J. H. Connor	
61. SIGNATURE OF DECEASED J. H. Connor		62. SIGNATURE OF NEXT OF KIN J. H. Connor		63. SIGNATURE OF CLERGYMAN J. H. Connor		64. SIGNATURE OF DECEASED J. H. Connor		65. SIGNATURE OF NEXT OF KIN J. H. Connor	
66. SIGNATURE OF DECEASED J. H. Connor		67. SIGNATURE OF NEXT OF KIN J. H. Connor		68. SIGNATURE OF CLERGYMAN J. H. Connor		69. SIGNATURE OF DECEASED J. H. Connor		70. SIGNATURE OF NEXT OF KIN J. H. Connor	
71. SIGNATURE OF DECEASED J. H. Connor		72. SIGNATURE OF NEXT OF KIN J. H. Connor		73. SIGNATURE OF CLERGYMAN J. H. Connor		74. SIGNATURE OF DECEASED J. H. Connor		75. SIGNATURE OF NEXT OF KIN J. H. Connor	
76. SIGNATURE OF DECEASED J. H. Connor		77. SIGNATURE OF NEXT OF KIN J. H. Connor		78. SIGNATURE OF CLERGYMAN J. H. Connor		79. SIGNATURE OF DECEASED J. H. Connor		80. SIGNATURE OF NEXT OF KIN J. H. Connor	
81. SIGNATURE OF DECEASED J. H. Connor		82. SIGNATURE OF NEXT OF KIN J. H. Connor		83. SIGNATURE OF CLERGYMAN J. H. Connor		84. SIGNATURE OF DECEASED J. H. Connor		85. SIGNATURE OF NEXT OF KIN J. H. Connor	
86. SIGNATURE OF DECEASED J. H. Connor		87. SIGNATURE OF NEXT OF KIN J. H. Connor		88. SIGNATURE OF CLERGYMAN J. H. Connor		89. SIGNATURE OF DECEASED J. H. Connor		90. SIGNATURE OF NEXT OF KIN J. H. Connor	
91. SIGNATURE OF DECEASED J. H. Connor		92. SIGNATURE OF NEXT OF KIN J. H. Connor		93. SIGNATURE OF CLERGYMAN J. H. Connor		94. SIGNATURE OF DECEASED J. H. Connor		95. SIGNATURE OF NEXT OF KIN J. H. Connor	
96. SIGNATURE OF DECEASED J. H. Connor		97. SIGNATURE OF NEXT OF KIN J. H. Connor		98. SIGNATURE OF CLERGYMAN J. H. Connor		99. SIGNATURE OF DECEASED J. H. Connor		100. SIGNATURE OF NEXT OF KIN J. H. Connor	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10529

10457

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	c. LENGTH OF STAY IN lb 18 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4004 Queensbury Road (Private home)		d. STREET ADDRESS 4004 Queensbury Road	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Sarah Loretta Vermillion	4. DATE OF DEATH Sept. 8, 19 58	5. SEX Female 6. COLOR OR RACE white 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH Sept. 17, 1879 9. AGE (in years last birthday) 78 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Vermillion		14. MOTHER'S MAIDEN NAME Mary Ryan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO.	
17. INFORMANT Lillian V. Erickson; 1509th Forest Glen Rd. Silver Springs, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac decompensation 421.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic valvular heart disease DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Sept. 8, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9-11-58	22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN	22d. LOCATION (City, town, or county) (State) BLADENSBURG MD.
23. FUNERAL DIRECTOR'S SIGNATURE Smithy Haddon		24a. REC'D BY REGISTRAR DATE SEP 15 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 913. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

REPORT OF THE COMMISSIONER OF HEALTH
ON THE STATE OF THE HEALTH OF THE PEOPLE
IN THE YEAR 1900

REPORT OF THE COMMISSIONER OF HEALTH
ON THE STATE OF THE HEALTH OF THE PEOPLE
IN THE YEAR 1900

NEW YORK: J. B. LIPPINCOTT COMPANY, 1901.

PRINTED BY THE STATE OF NEW YORK, 1901.

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PRINTED BY THE STATE OF NEW YORK, 1901.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10530

Reg. Dist. No.

10542

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Piscataway</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Piscataway</u>	
c. LENGTH OF STAY IN 1b <u>10 years</u>		d. STREET ADDRESS <u>Route #2 Box 200</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route #2 Box 200</u>		e. IS RESIDENCE IN A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) <u>Willie Walbanks Vess</u>		4. DATE OF DEATH <u>Sept 8 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 30 1906</u>
9. AGE (In years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Walbanks</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Ashmore</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Robert L Vess, same as #2</u>	
17. INFORMANT <u>Robert L Vess, same as #2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subdural hematoma</u> <u>904.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Blow on head</u> (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell and struck head on table</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>9-7 1958</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) a. <u>Piscataway</u> (County) <u>PS</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>James I. Boyd</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>Sept 8, 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-10-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Linmon Bros. 1661 Good Hope Rd. S.E.</u>		24a. REC'D BY REGISTRAR <u>SEP 10 1958</u>	
24b. REGISTRAR'S SIGNATURE <u>Linmon Bros.</u>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED <i>John J. Jones</i>		AGE <i>45</i>	SEX <i>M</i>	RACE <i>W</i>
RESIDENCE <i>123 Main St. Baltimore, Md.</i>		DATE OF DEATH <i>Jan 15 1915</i>		
PLACE OF DEATH <i>Home</i>		CAUSE OF DEATH <i>Myocardial Infarction</i>		
MANNER OF DEATH <i>Natural</i>		DISEASE OR INJURY <i>Coronary Artery Disease</i>		
SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		SIGNATURE OF MEDICAL EXAMINER <i>Dr. J. H. Smith</i>		
DATE OF EXAMINATION <i>Jan 15 1915</i>		TIME OF EXAMINATION <i>10:00 AM</i>		
PLACE OF EXAMINATION <i>Home</i>		SIGNATURE OF WITNESSES <i>John J. Jones, Jr. Mary J. Jones</i>		
DATE OF BURIAL <i>Jan 16 1915</i>		PLACE OF BURIAL <i>St. Mary's Cemetery</i>		
SIGNATURE OF BURIAL OFFICIAL <i>John J. Jones</i>		SIGNATURE OF MEDICAL EXAMINER <i>Dr. J. H. Smith</i>		

CERTIFICATE OF DEATH

Reg. Dist. No.

10531

10543

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SUITLAND</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SUITLAND</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5631 SHADYSIDE AVE.</u>		d. STREET ADDRESS <u>5631 SHADYSIDE AVE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>GIOVANNA</u> <u>Vidi</u>		4. DATE OF DEATH Month Day Year <u>SEPT</u> <u>18</u> <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 1, 1892</u>
9. AGE (In years last birthday) yrs. <u>66</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>ITALY</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Pietro Zanehotti</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Vittorio Vidi</u>		Address <u>5631 Shady Side Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>AUTO MYOCARDIAL INFARCTION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 Minute</u> <u>2 1/2 hrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X DIABETES MELLITUS</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-9-57</u> , 19____, to <u>9-18-58</u> , 19____, that I last saw the deceased alive on <u>9-11-58</u> , 19____, and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lewis H Biben</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>915 19TH ST NW</u> <u>9-18-58</u>	
PHYSICIAN'S NAME (Type) <u>LEWIS H. BIBEN</u>		<u>WASHINGTON DC</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>SEPT. 22, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BLADENSBURG MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>RINALDI FUNERAL HOME</u>		ADDRESS <u>816 H ST. N.E.</u>	
24a. REC'D BY REGISTRAR <u>SEP 22 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10513

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edmonston	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital			d. STREET ADDRESS 4913 49th Avenue		
3. NAME OF DECEASED (Type or print) Frances Naomi Williams			4. DATE OF DEATH Sept. 16 19 58		
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 3, 1910		9. AGE (In years last birthday) 47 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph Coughlin			14. MOTHER'S MAIDEN NAME Annie Davis		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Dwight H. Williams: same address as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Purulent dermoid cyst of right ovary, splenomegalia, uterine fibroids					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED September 17, 1958	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/19/58	22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		22d. LOCATION (City, town, or county) Colmar Manor Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons		ADDRESS 4739 Balto. Ave. Hyattsville, Md.		REC'D BY REGISTRAR SEP 23 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2202 Churchy Ave.
Churchy, md

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CERTIFICATE OF DEATH

10534

Reg. Dist. No.

10544

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Heights</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Forest Heights. (D.C. 21)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>11 Delaware Drive S.E.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Janie</u> Middle <u>Elizabeth</u> Last <u>Williams</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>3</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 7, 1864</u>
9. AGE (In years last birthday) <u>94</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Phoenix, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Turnbaugh</u>		14. MOTHER'S MAIDEN NAME <u>Cecelia Knight</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. William Disney</u>		Address <u>11-Delaware Drive</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Right Hemiplegia</u> DUE TO (c) <u>Senility & Arterio-Sclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>6 hours</u> <u>8 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April</u> , 19 <u>50</u> , to <u>Sept 3</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9/2/58</u> , 19 <u> </u> , and that death occurred at <u>2:35 A.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7519 Broadview Rd S.E.</u> DATE SIGNED <u>9/3/58</u>			
ACTUAL SIGNATURE <u>Anna Coyne Todd</u>		M.D. <u>7519 Broadview Rd S.E.</u>	
PHYSICIAN'S NAME (Type) <u>Anna Coyne Todd</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept 5-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>	22d. LOCATION (City, town, or county) (State) <u>Bladensburg, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Summers Bros</u> ADDRESS <u>1661-gard Hope Rd S.E.</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>SEP 4 '58</u>	24b. REGISTRAR'S SIGNATURE <u> </u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10535

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

10514

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	c. LENGTH OF STAY IN 1b 16 Days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 3801 Nicholson St.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Ada Middle Mae Last Woodward	4. DATE OF DEATH Month Sept. Day 12, Year 19 58		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 30, 1867
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Washington D.C.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Mason Anderson		14. MOTHER'S MAIDEN NAME Amanda Young	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Louise Woodward		Address 5517 Kennedy St. Riverdale, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO (b) Fracture of right femur Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardiovascular renal disease			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall in home	
20c. TIME OF INJURY Month, Day, Year Hour 8/28 19 58 p. m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Hyattsville (County) Pr. Geo. (State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED September 12, 1958	
EXAMINER'S NAME (Type) John T. Maloney		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept 15, 1958	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		24a. REC'D BY REGISTRAR SEP 16 '58	
ADDRESS Hyattsville, Maryland.		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10515

CERTIFICATE OF DEATH

10536

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 9 hrs 45min.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Bradford Last Wright		4. DATE OF DEATH Month September Day 27 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/16/23
9. AGE (In years last birthday) 35 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Carpenter	
11. BIRTHPLACE (State or foreign country) Staunton, Va.		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Emmett Newton Wright		14. MOTHER'S MAIDEN NAME Gladys Enola Walden	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Virginia E. Wright		Address 4700 Kiernan Road Wife	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Intracranial Hemorrhage 1939 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Left Glob. Blastoma Cerebri DUE TO (c)		PARTIAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 26 19 58 , to September 27 19 58 , that I last saw the deceased alive on September 27 , 19 58 , and that death occurred at 6 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Benjamin S. Miller		ADDRESS (Street, city or town, state) 3824-34th N. Lauma Sept 27 58	
PHYSICIAN'S NAME (Type) Benjamin S. Miller M.D.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/30/1958	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Colmar Manor, Pr. Geo. Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company,		ADDRESS Riverdale, Md.	
24a. REC'D BY REGISTRAR SEP 30 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Faus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

